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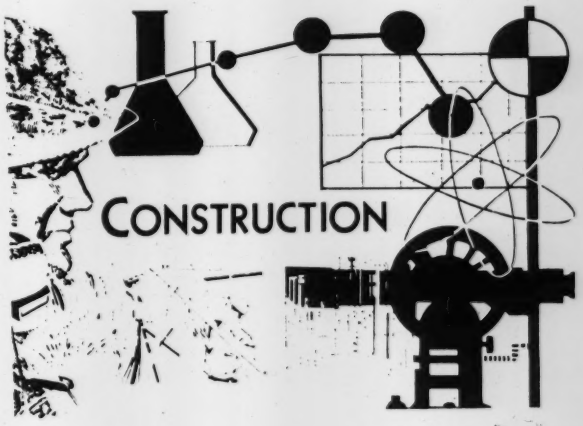

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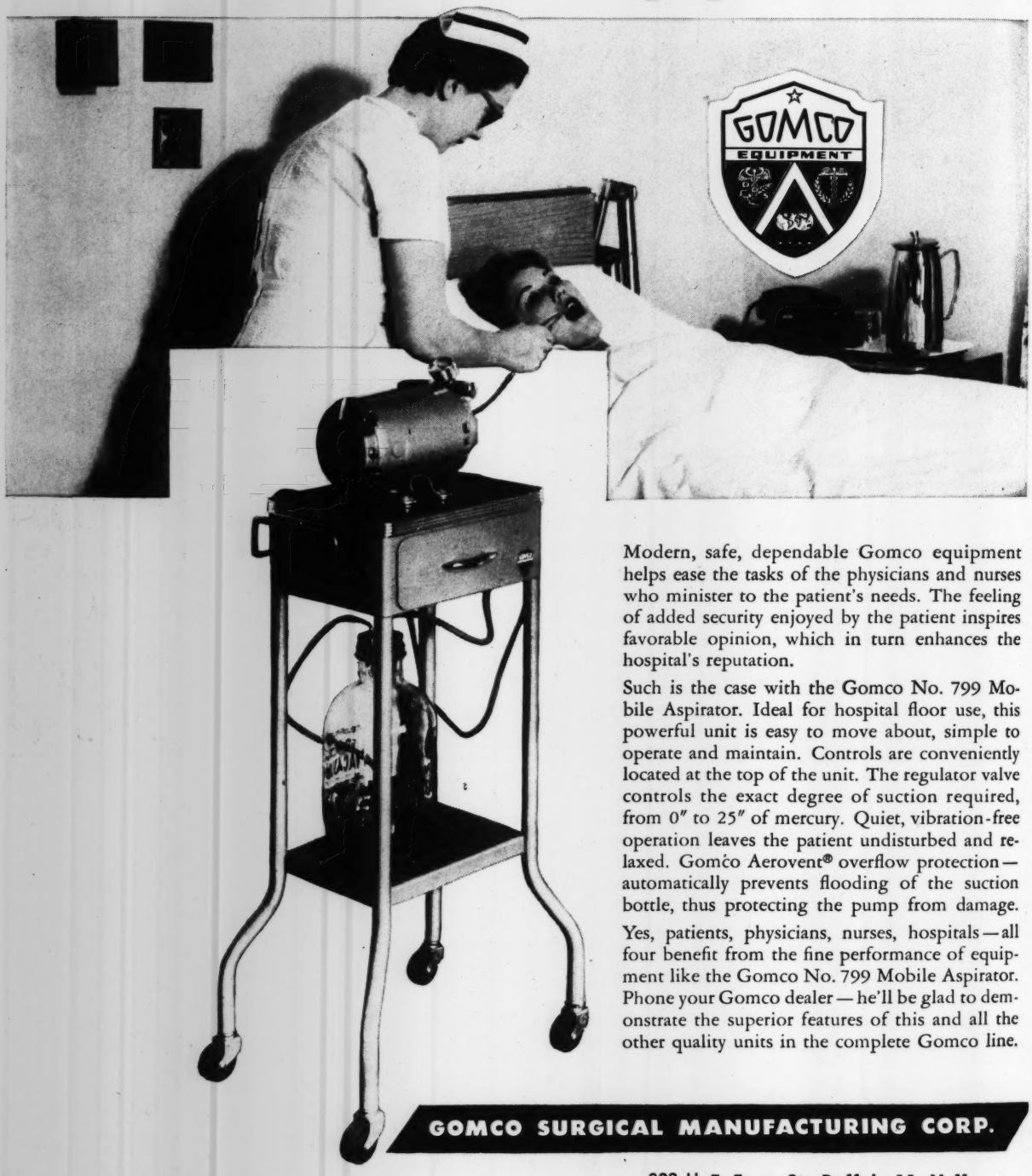

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CONTENTS

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BUILDING SECTION

		Page
Planning Means Success (Editorial)		61
Tomorrow's Hospital	*Anthony J. J. Rourke, M.D.*	62
Analytical Approach to Hospital Planning, The	*Roy Hudenburg*	66
Purchasing Equipment for Hospital Construction	*J. Fred Knight*	70
1936: A Medical Outpost— 1960: A Medical Center	*James S. Moore, A.I.A.*	72
New St. Anne's Home, The	*Msgr. Arthur E. Ratigan, Paul Duffy, M.D., Robert Hall, A.I.A.*	74
Hospital of the Future, The?	*Charles E. Berry*	77
Planning Food Facilities for Hospitals	*Richard R. Iuen, A.I.A.*	78
New Approach to Intensive Care, A	*David DeBacker*	81
Catholic Hospital Construction	*Dan Roberts*	84
Fantasyland for Small Fry	*Marie T. Aubuchon*	132
Preventive Maintenance	*Anne J. Vestal*	122

DEPARTMENTS

BOOKS RECEIVED		20
CALENDAR		10
CANON LAW: Responsibility for Debts	*Rev. Francis N. Korth, S.J.*	12
CLINICAL LAB: The Spirit of a Teaching Program	*Rev. John L. Thomas, S.J.*	108
DEAR SISTER MICHAELEEN	*"Father Brian"*	104
DIETARY: Planning Food Facilities for Hospitals	*Richard R. Iuen, A.I.A.*	78
EDITORIAL: Planning Means Success	*H.R.B.*	61
HOSPITAL HISTORY: S. Giacomo in Augusta	*Rev. Alphonse M. Schwitalla, S.J.*	96
HOUSEKEEPING: Preventive Maintenance	*Anne J. Vestal*	122
ITINERANT, THE		24
LAW FORUM: Legal Authority in Hospital Management	*Wm. A. Regan*	102
LIBRARY SERVICE: Mission Hospital Libraries Need Help!	*Sr. M. Nathaniel, S.C.M.M.*	116
MAINTENANCE: Preventive Maintenance	*Anne J. Vestal*	122
MENTAL HEALTH: Family Reactions to Mental Illness	*Rev. A. H. Scheller, S.J.*	90
MATERNITY CARE: Family-Centered Maternity Care	*Sr. M. Stella, D.C.*	92
NATIONAL NEWS: Laws & Legislation	*George Reed*	95
NEWS		42
NEW SUPPLIES & EQUIPMENT		170
NURSING EDUCATION: A Faculty's Choice	*Sr. Anne Joachim, C.S.J.*	98
NURSING SERVICE: The Head Nurse is a Manager	*Angela C. Coletti*	100
PEOPLE & PLACES	*Marie T. Aubuchon*	156
PERSONNEL: Work Simplification Applied to Hospitals	*John W. Hankins*	133
PURCHASING: Purchasing Equipment for Hospital Construction	*J. Fred Knight*	70

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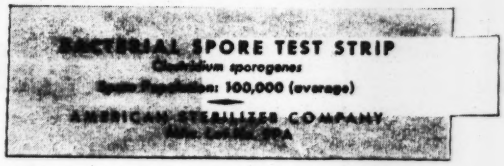

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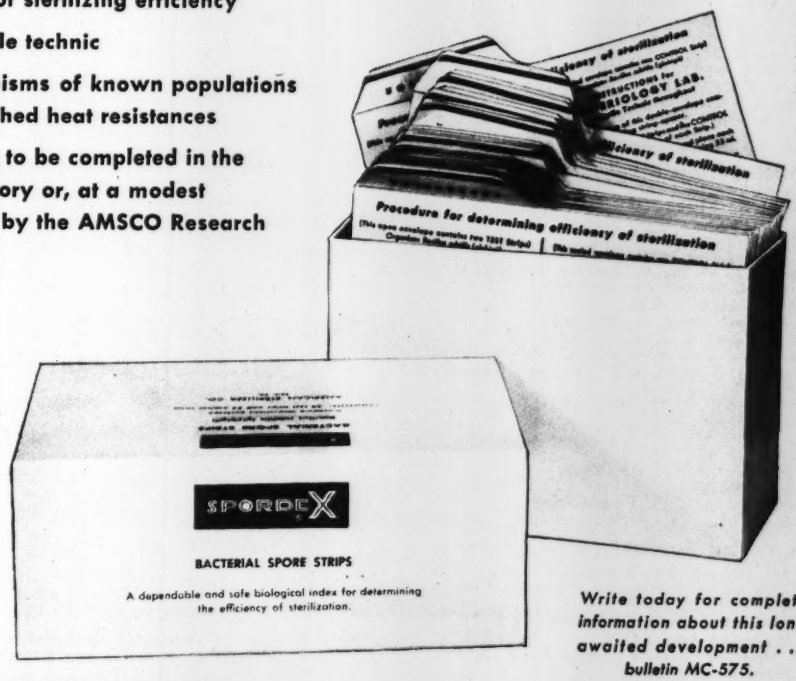
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Patron of Catholic Hospitals and the Sick, of Religious and Lay Nurses of Both Sexes **8**

St. Joseph
Selected as Patron of Procurators and Business Office Workers **19**

Wisconsin Hospital Association, Schroeder Hotel, Milwaukee, Wis. **10**

American Academy of General Practice, 12th Annual Scientific Assembly, Convention Hall, Philadelphia, Pa. **21-24**

Louisiana Hospital Association, Bellemont Motor Hotel, Baton Rouge, La. **24-26**

New England Hospital Assembly, Statler-Hilton Hotel, Boston, Mass. **28-30**

Kentucky Hospital Association, Kentucky Hotel, Louisville, Ky. **29-31**

Georgia Hospital Association, Jekyll Island, Ga. **31-April 1**

APRIL

St. Gemma Galgani
Patron of Hospital Pharmacists **16**

St. Catherine of Siena
Selected as Patron of Nurses and Nursing Service **30**

Ohio Hospital Association, Veterans Memorial Building, Columbus, Ohio **4-7**

Pennsylvania Association of Medical Record Librarians, Governor Hotel, Harrisburg, Pa. **7-8**

Institute for Medical Record Librarians, sponsored by South Dakota Association for Medical Record Librarians, Park Hotel, Madison, N. D. **10**

Carolinas-Virginias Hospital Conference, Roanoke Hotel, Roanoke, Va. **21-22**

Association of Western Hospitals, Statler-Hilton Hotel, Los Angeles, Calif. **25-28**

Middle-Atlantic Hospital Assembly, Convention Hall, Atlantic City, N. J. **27-29**

Mid-West Hospital Association, Municipal Auditorium, Kansas City, Mo. **27-29**

Iowa Hospital Association, Hotel Roosevelt, Cedar Rapids, Ia. ... **28-29**

MAY

Tri-State Hospital Assembly, Palmer House, Chicago, Ill. **2-4**

American Nurses' Association, Miami Beach Hall, Miami Beach, Fla. **2-6**

Pan American Medical Association, National Auditorium, Mexico City, Mexico **2-11**

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CANON LAW

Responsibility For Debts

by **FRANCIS N. KORTH, S.J.**

ADMINISTRATORS of ecclesiastical goods or property are well aware of the fact that they are administering the property belonging to a moral ecclesiastical person and not property belonging to themselves. As a result they may not dispose of these temporal goods as they wish, but only in conformity with the prescriptions of canon and civil law, insofar as each is applicable in a particular case. In this connection canon 536 notes that the moral person contracting debts and obligations, whether it be an institute, a province, or a house, is itself alone responsible for them. The fact that superiors have given the necessary permission to contract such debts does not make them responsible. Bouscaren-Ellis (*Canon Law: a Text and Commentary,* 3rd revised edition, 1957, p. 251) remark that in order to avoid misunderstandings the above fact should be made known to creditors when debts are contracted; if the institute wishes to assume responsibility for the debts of one of its provinces or houses, it may do so if the proper authorities according to the Constitutions give their consent. If the Constitutions provide for only one subject of ownership in the entire institute, the above would be applicable in the sense, as it is applicable in other cases also, that the Holy See is not responsible even though its permission is necessary in certain instances for the validity of the contract.

If a religious with *simple* vows contracts a debt or obligation even with permission, he or she alone is responsible, unless he or she was doing business for the institute with the superior's permission (c. 536, §2). Likewise if a religious contracts debts or other obligations without any permission of superiors, it is not the institute nor the province nor the house that is responsible, but the religious alone (c. 536, §3). In this case a religious with simple vows would have to pay the debt out of his own patrimony (if he has any). It is a fixed rule, however, that suit may be brought against the person (moral or physical) who has profited by the contract (c. 536, §4).

Lawsuits

In this connection a brief word about lawsuits may be in place. c. 1649 remarks that the rector or administrator of an ecclesiastical moral person, collegiate or non-collegiate, can act for the moral person in a lawsuit. Concerning religious institutes, c. 1653, §6 states that religious superiors represent their houses, provinces or institutes in such suits according to their

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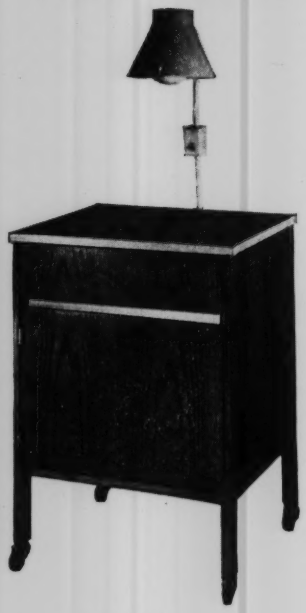

Front view of cabinet with lamp in position.

With this bedside cabinet lamp the doctor or nurse can quickly and easily put the light exactly where it is needed for examination or treatment. The lamp is mounted on the back side of the cabinet and rolls on a track, so it may be easily moved and used on either side of the cabinet as required. It may also be moved entirely out of the way when full access to the top of the cabinet is desired. The shade is well ventilated—will never become hot.

A convenience outlet permits plugging in any electrical appliance used at the bedside.

This lamp is completely approved by Underwriters' Laboratories, Inc. as safe for hospital use.

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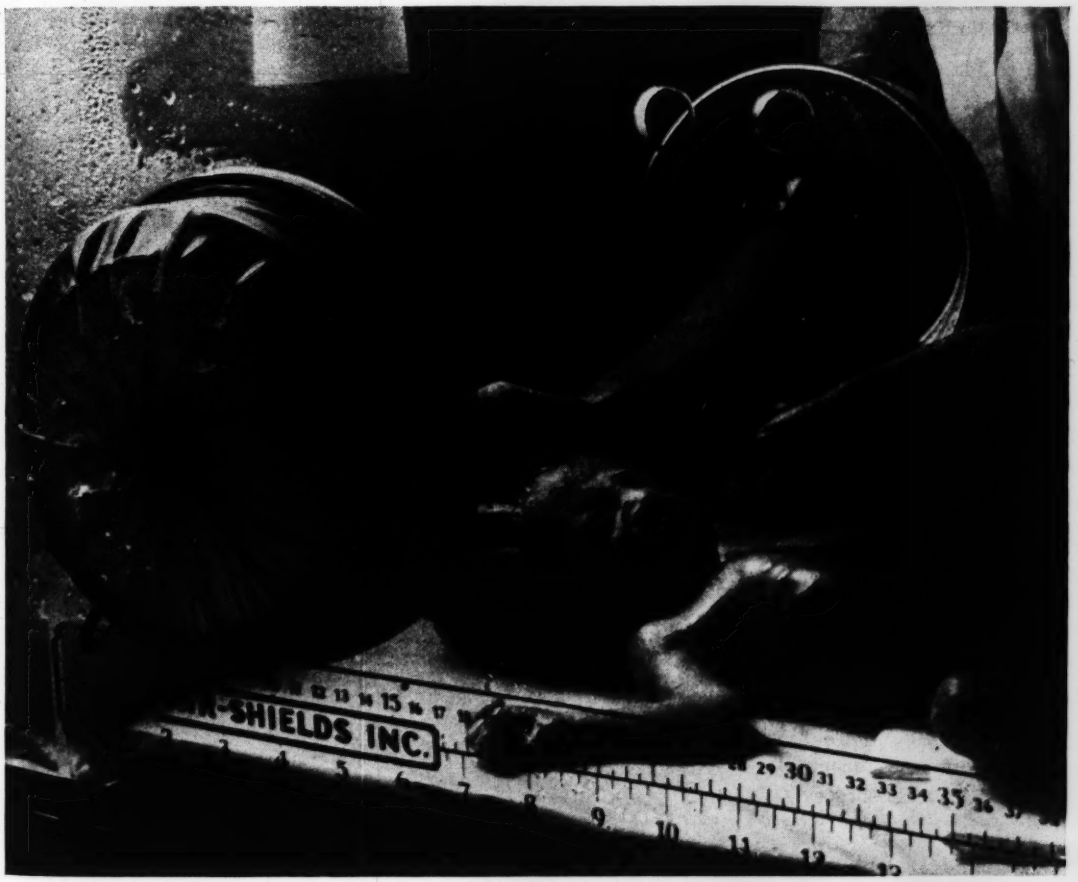
Constitutions. Vromant, (*De Bonis Ecclesiae Temporalibus,* 3rd revised edition, 1953, n. 221) in commenting on this canon, says that if the Constitutions permit superiors to act in this matter, they need no other permission; if the Constitutions and particular laws make no provision, the superior can act since his power of ordinary administration in these matters is not impeded by any explicit precept. (In a previous article on some general points about administration, in connection with the explanation of acts of ordinary and extraordinary administration we have seen the opinion of a recent commentator to the effect that if a modification of stable assets is involved, the act is one of extraordinary administration.)

C. 1526 provides that administrators are not to enter a suit or a defense to a suit in the name of the Church unless they have obtained the written permission of the local Ordinary, or in emergencies, of the rural dean. This canon applies also when there is question of a suit in an ecclesiastical court. Hence even for a suit in an ecclesiastical court, superiors of a religious institute of *diocesan* right are to follow the provisions of their own Constitutions and also obtain prior permission from the local Ordinary and observe whatever directions he might give at that time. Because of c. 618, §2, n. 1, superiors of religious institutes of *pontifical* right, however, are not bound to obtain the prior written permission of the local Ordinary as mentioned in c. 1526 in case of a suit. The prohibition of c. 1526 applies only to ecclesiastical property subject to the jurisdiction of the local Ordinary.

Furthermore, in virtue of c. 614 religious enjoy the privilege of c. 120 whereby, if the case arises, they should be cited before an ecclesiastical court rather than before a civil court, unless the permission of the Ordinary of the place where the case will be tried has been obtained; if there were question of a superior general of a religious institute of pontifical right, the permission of the Holy See would be necessary. In the United States it seems not much attention is being paid to respecting this privilege of clerics and religious.

It might be advantageous for any religious superior who is faced with the problem of a lawsuit to consult the Vicar for Religious in the Chancery Office; he might be in a position to give some good advice in the matter. ★

Greater promise for survival within the "protective shell" of the ISOLETTE®



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For absolute isolation, fresh, pathogen-free, circulating outside air is made available only by the ISOLETTE. When nursery air must be used, addition of the new MICRO-FILTER to the ISOLETTE incubator provides pathogen-filtered air by removing all air-borne contaminants down to 0.5 micron in size. Moreover, ". . . a humidity of 80 to 90 percent can be obtained only in incubators with forced ventilation (e. g., the ISOLETTE)."[2]

For additional information about the ISOLETTE, write to AIR-SHIELDS, INC., Hatboro, Pa. or phone us collect from any point in the U.S.A. (OSborne 5-5200).

1. Lynn, H.B.: Postgrad. Med., 22:429, 1957.
2. Dancis, J.: Postgrad. Med., 22:194, 1957.

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1

Type 1-L. A single-lane Folder for large pieces. Used with any 110″ or 120″ Ironer.

2

Type 2EF-LM.A 2-lane or single-lane Folder for both large and small pieces. The flip of a switch will change it from two to one or one to two-lane operation. Use it with any 110″ or 120″ Ironer.

3

Type 2EF-LS. Control *automatically* changes Folder back and forth for two-lane or single-lane operation as different size pieces pass through. Folds large and small pieces directly from any 110″ or 120″ Ironer.

4

Type 2EF-FS. A 2-lane or single-lane Folder especially designed for family service flatwork. A "pick-up" conveyor delivers pieces too small for mechanical folding to a Receiving Tray beneath the Delivery Table. Change back and forth for one or two-lane operation is automatic.

5

Type 3EF-BA. Automatically folds bib aprons in three 40″-wide lanes directly from any 120″ Ironer. A manual selector instantly combines the three lanes into a single 120″-wide lane for folding large pieces.

6

Type 4EF. Four lanes, two lanes or one lane as you need them. The four 30″-wide lanes operate independently, boost production by eliminating stagger-feeding. A manual control also sets Folder for operation of two 60″-wide lanes or one 120″-wide lane.

7

Type 4UF-BA. Four, three, two, or single-lane folding with the flip of a switch! Ideal for part-time folding of bib aprons. Manual control sets Folder for 4 lanes (two 40″ and two 20″-wide), 3 lanes (each 40″-wide), 2 lanes (each 60″-wide) or 1 lane (120″-wide).

8

Type 5EF. Five, three, two or one-lane operation gives unusual flexibility to handle a wide variety of flatwork on a single Folder. Simple control changes from 5-lane (each 24″-wide) to 3-lane (two 48″-wide and one 24″-wide) to 2-lane (one 72″-wide and one 48″-wide) or to 1-lane (120″-wide) as needed.

9

Type 5EF-BA. The same five, three, two and one-lane flexibility as the Type 5EF, plus special features for plants using a 120″ Ironer part time for bib aprons.

Ask your American representative to arrange for you to see our new motion picture on the TRUMATIC FOLDER.

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A good all-purpose restraint to prevent patients from falling or getting out of bed. Particularly good for use on females as it does not irritate busts. Available in Small, Medium and Large sizes.
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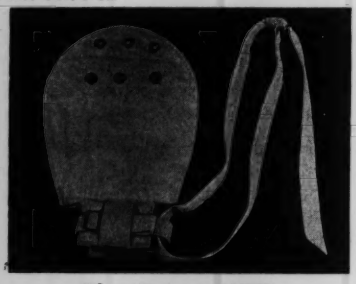

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Cat. No. C-212 — (both sides flexible) $6.00 ea.—$12.00 pr.
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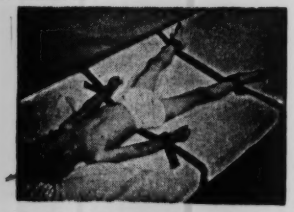
To limit the patient's hand activity. An adjustable strap attached to the mitt and the side rail of the spring determine limit of movement. Can be laundered by ordinary methods. Prevents patient's scratching, pulling out catheter, nasal tube, etc. Available small, medium and large. Not uncomfortable.



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A friendly restraint available in Infant, Small, Medium and Large sizes. Also widely used for holding extremity during intravenous injection. No. P-450. $5.70 per pair. $11.40 per set; with sponge rubber padding $6.70 per pair, $13.40 per set.

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The Itinerant

These are gleanings from today's world, peripatetic views of the news. Not always of a medical or hospital nature, these brief notes will sometimes deal with the scientific, the international, the literary, the purely cultural. Wherever Man is there is news—and there will be the Itinerant, committed to no deadlines—writing only when material at hand seems worthy of your notice.

PITTSBURGH, PA. . . . Eight months ago, physicians were working desperately to save the life of Sister Brian Brennan, O.S.F., who had her arm caught in a large mangler in the laundry of St. Joseph's Home for Aged Women.

To save her life, doctors were forced to amputate her left arm, six inches below the shoulder. Yet today, Sister Brian Brennan is an active, useful member of the community. Her story is one of courage, faith and the effectiveness of modern rehabilitation techniques.

Sister is fitted with an artificial device known familiarly to arm amputees of World War II. The device enables her to do the most complicated tasks—like tying shoes, carrying trays of food, or cracking an egg.

Skin grafts had left Sister's shoulder tender and at first use of her "new arm" was painful. Gradually this pain lessened and soon Sister Brian Brennan found her skill increasing in use of the arm. Trips to the Rehabilitation Institute at New York University's Bellevue Medical Center sharpened this skill. Then, too, there were countless prayers.

Now there is little that Sister Brian Brennan cannot do.

REGENSBERG, GERMANY . . . Crucifixes have been replaced on the walls of Regensberg courtrooms after an absence of more than 25 years. Crucifixes were removed by Nazi authorities shortly after Hitler's seizure of power. Their replacement was ordered recently by the president of a high provincial court.

The first three crucifixes, carved by inmates of the Straubine penitentiary, were blessed by a Regensburg priest in the presence of several magistrates.

NEW HAVEN, CONN. . . . An extremely valuable and rare volume of 15th century medical "receipts" just acquired by Yale University spells out in Chaucerian English more than 450 ways to alleviate man's pains.

According to Frederick G. Kilgour, librarian at Yale's School of Medicine, the handwritten book is one of the few existing examples of late Chaucerian use of medical and scientific writing. Measuring eight by six inches, the book contains 204 pages and is covered by worm eaten wooden boards, but the text dating back to 1420 is undamaged.

On "broken bonys" (broken bones) —Take green scum, a daisy, a seed plant and the top of a root and two spoonsful of honey. Give this to the patient to drink five times a day. But, first, make sure the bone is set evenly.

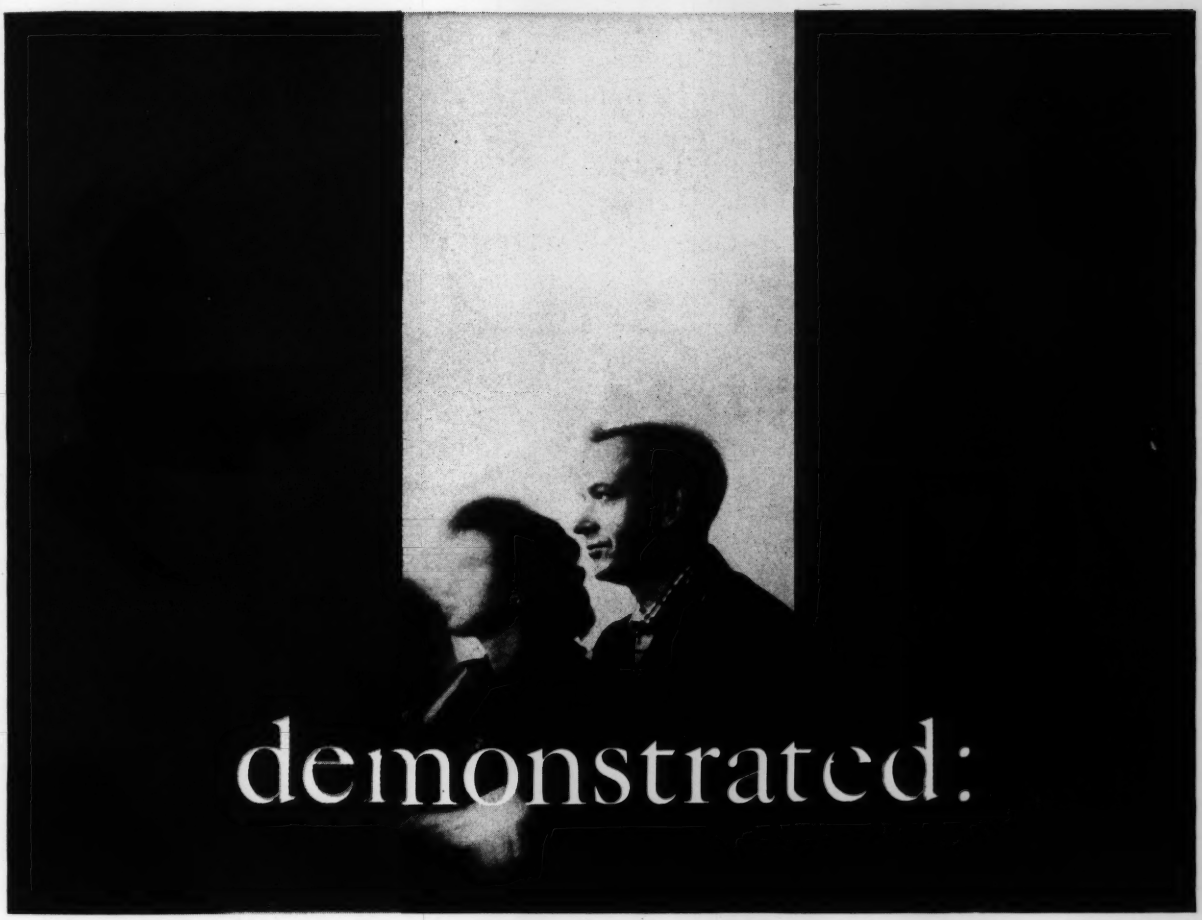
All this probably gave the patient a seizure of violent indigestion, but undoubtedly his bone was healed because of the last sentence about making sure the bone was set evenly.

For "akyng of teth" (a toothache)— Find a spurge—wild plant—that has a round leaf. Crush the plant and you'll find a drop of liquid that looks like milk. Put this fluid behind the tendon on the opening side of the patient's ear. This will cause a blister underneath. Drain the blister and it will make you well. Also take a clove of garlic, break it in half and bind it to the pulse. Do this for a night and a day and in the morning, loosen it and on the side you see the blister, drain out the water.

Nothing is said about winning back the friends who have abandoned you because of that smell of garlic on the pulse.

On insomnia—For unkindly heat in the head that keeps a man from sleeping. Rx—the juice of Nightshade that is moral and wet a cloth in the juice, and anoint the head cross-wise and also the flat part of the hand and he shal soon go to sleep perfectly.

No clue can be found, by the way, to what happens to the poor insomniac that is annointed with "immoral" Nightshade. ★



IN SURGERY—Generally successful in 60 patients... no infection developed in prophylaxis group... most frank infections responded including some refractory to other drugs. Dosage 600 mg. daily or less. Excellent toleration.[3]

IN CLINIC—Full resolution in 150 soft tissue infections. Transient side effects in two per cent. Dosage 600 or 750 mg. daily for average of six days (alone or with surgical measures).[4]

ON WARD—Successful in all 32 acute pneumonias but two. Seventeen were complicated by underlying bronchopulmonary problems. Dosage low. No toxicity. Acceptance, toleration excellent.[2]

AND ACROSS THE SPECTRUM—87 per cent of 2384 cases reported cured or improved. Dosage usually 600 mg. daily.[1]

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- lower milligram intake
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- extra-day protection against relapse

CAPSULES, 150 mg./**PEDIATRIC DROPS,** 60 mg./cc./**ORAL SUSPENSION,** 75 mg./5 cc. tsp.

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A.C.H.A. REPORT

3rd congress attracts record attendance

ARTICLE AWARD was presented to Father Robert J. Henle, S.J., and the annual Edgar C. Hayhow Award to Dr. Oswald Hall (r.) by Richard D. Vanderwarker, (l.) vice-president, Memorial Center for Cancer & Allied Diseases, New York City.

DRAWING STRENGTH from their own excellence, the annual mid-year congresses on administration of the American College of Hospital Administrators continue to attract more registrants each year. (The truly objective observer is forced to note that the regents wisely schedule membership examinations concurrently.) More than 800 registrants had been tallied before the third two-day congress opened at Chicago's Morrison Hotel Feb. 5, 1960.

Devoted to management topics, the sessions were planned around some 20 breakfast seminars, repeated Friday and Saturday, and four general sessions.

The first general session speaker was C. Northcote Parkinson, Ph.D., *discoverer* (not inventor, if you please) of "Parkinson's Law." His delineation of the (organic) growth of committees was contained in a delightful vagary on "Commitology"—which he also claims as his personal discovery. In a very refreshing and perceptive satire, Dr. Parkinson ranged through "the perversities of corporate behavior" through which the modern organization man inevitably arrives at the "coefficient of inefficiency."

The highlight of the congress for this reporter was, rather naturally, the presentation of a plaque on Friday afternoon to Father Robert J. Henle, S.J., dean of the Graduate School at St. Louis University and winner of the Article Award Competition for 1959. The award was presented to Father Henle for his "Intellectual Development of the Operationalist," printed in HOSPITAL PROGRESS—May, 1959. The first Edgar C. Hayhow Award, honoring the 14th president of the College, was awarded to Dr. Oswald Hall, professor of sociology at the University of Toronto. He was given the award for a paper, "Motivation and Morale," published in *Hospital Administration,* the journal of the College. The College's "Hospital Administrator's Award"—and a $500 cash prize—was presented to Harold J. Leavitt, professor at the Carnegie Institute of Technology, Pittsburgh, Pa. Professor Leavitt discussed the topic of his prize-winning book, *Managerial Psychology.* He predicted the recognition and increasing utilization of "Eggheads" (highly educated problem solvers) in organizations, especially industry.

He characterized present day man-

(Continued on page 32)

NEW EVIDENCE SUGGESTS ANOTHER REASON FOR PRESCRIBING TAO

The impression that TAO is an unusually active antibiotic has steadily gained recognition by impressive clinical performance. Now come reports of **in vivo** and **in vitro** biological and biochemical evaluations that show TAO to be indeed unique.[1,2]

TAO differs from other antibiotics in that it is metabolized to multiple active compounds which **remain** active throughout their presence in the body. These 7 derivatives (in addition to TAO) show activity against common Gram-positive pathogens, including resistant strains of **Staph. aureus.**

In light of these findings, take another look at TAO performance: • 92% success in published cases of Gram-positive respiratory, skin, soft tissue and genitourinary infection • Effective against 78% of 64 "antibiotic-resistant" epidemic staphylococci. (In the same study, chloramphenicol was active against 52%; erythromycin against only 25%)[3] • No side effects in 94%; infrequent reactions mild and easily reversed • Quickly absorbed • Highly palatable.

Sound reasons to: Start with TAO to end 9 out of 10 common Gram-positive infections.

Supplied: TAO Capsules—250 mg., and 125 mg., bottles of 60. **TAO for Oral Suspension**—125 mg. per tsp. (5 cc.) when reconstituted; unusually palatable cherry flavor; 60 cc. bottle. Prescription only.

Other TAO forms available: TAO Pediatric Drops: flavorful, easy to administer. **TAO®-AC:** TAO analgesic, antihistaminic compound. **TAOMID®: TAO with triple sulfas. Intramuscular or Intravenous:** in clinical emergencies. Prescription only.

1. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. 100:880 (Apr.) 1959. 2. Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277. 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.

designed for superior control of common Gram-positive infections

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(triacetyloleandomycin)
Capsules/Oral Suspension

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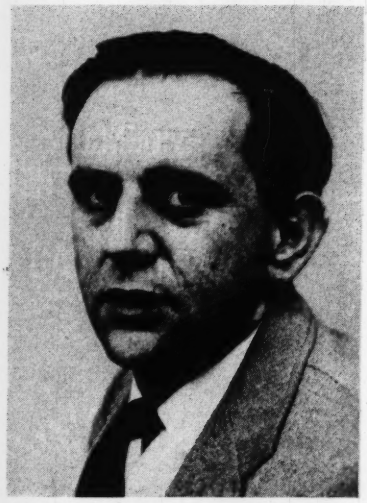
Science for the World's Well-Being

A.C.H.A.
3rd Congress

(Begins on page 28)

agement as heavy in the middle with managers who make judgmental decisions for top management, while industrial engineers, at the lower level of management, concern themselves with the muscles and machines of industry. The existence of a large class of "middle managers," he said, tends to keep wide the gulf between top management and the workers. Technology, embracing operations research, linear programming and high speed computer research, will tend to replace these middle managers and give real control back to top management. He predicted the present emphasis on participative management would be replaced by a move toward socio-analytic management, cognizant of both the social and quantitative elements in problem solving. He said management will use "Eggheads"—a term we would as soon had never been coined—because their methods will work and will tend to absorb uncertainty and provide top management with more control.



HAROLD J. LEAVITT, Professor at the Carnegie Institute of Technology, Pittsburgh, Pa., was awarded the annual Hospital Administrator's Award."

Pointing to a possible trend toward recentralization in industry, he said the current decentralization is due to the judgmental function now required at the middle management level.

Lyle M. Spencer, president, Science Research Associates, Chicago, addressed the Saturday morning general session, evaluating the use of psychological testing by management for hiring and promotion. He cautioned that the value of measurement tests depends on their proper administration and interpretation. They have a certain margin of error, just as do tests in the laboratory, and the tested "intelligence" of a person is not as important to an employer as the willingness and ability to apply it.

He said 11,000 business firms use tests of some sort in personnel selection and these are sometimes used as a crutch or excuse to dodge responsibility in making selections. They are really only helpful as an aid to one's own skill in making the hiring decision and their greatest asset is to add fairness and impartiality to the criteria. He said tests can compare the "batting average" of employes and help them avoid mistakes and cited this quality as the principal reason for their growth in industry.

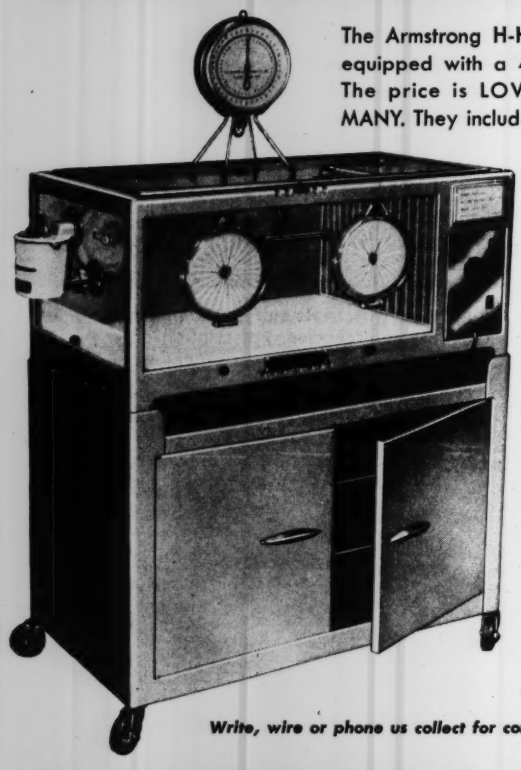
He said tests are most successful if used in relation to simple work, but cannot evaluate creativity. They can show an individual what he can do and what he knows. They cannot show him what he *will* do.

"New Approaches to Executive

(Continued on page 38)

Armstrong H-H

Hand-hole type Baby Incubator



The Armstrong H-H is a LARGE incubator equipped with a 40% oxygen nebulizer. The price is LOW—the FEATURES are MANY. They include:

- 4-compartment mobile cabinet
- 40% oxygen limiting valve
- 3-stage humidity reservoir
- slide-opening for tube-feeding
- emergency opening top-lid—safety glass
- clear plexiglas ends and sides
- foam mattress with plastic cover
- 2 pre-shrunk weighing hammocks
- large enough for a 25-inch baby

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Reflexomatic is a term used by General Electric to describe the performance of its spot-film units and radiographic tube hangers as they react to the world's finest guidance system: *your own hand.*

No mechanism devised by man has approached the infinite precision and delicacy, the instant response which can be provided by the human hand. That is why *your hand* directly commands these elements of General Electric x-ray equipment. This is why General Electric designs unique counterbalancing and mechanical linkage systems to translate your very thoughts into "reflexomatic" reaction of certain x-ray devices.

Developed to the high degree of perfection found in G-E diagnostic x-ray units, you'll find no adequate substitute. Your brain signals . . . your hand acts . . . the equipment responds. In short, your very reflexes control mechanical actions, while you concentrate on diagnosis!

You be the judge. Ask your General Electric x-ray representative to arrange a date for you to test this "reflexomatic" principle in any way you choose. Discover for yourself why it lets nothing stand in the way of your diagnostic skill . . . how it puts a world of convenience in the very palm of your hand.

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A.C.H.A.

3rd Congress

(Begins on page 28)

Training" was the subject of the luncheon address on Saturday, honoring preceptors. The speaker was Leland P. Bradford, director, National Training Laboratories, Washington, D.C. He cited the increasing use of managers in industry and said it was due to growth of companies, expanding population and increase in social complexities and changing patterns of work. He said social complexity has brought about group decision making to replace individual decision and the changing patterns of work are due to change in procedures, in management and in the workers.

Training of executives must emphasize adaptability to change and enable the trainee to expect and deal with ambiguity in his relations with others, Mr. Bradford said. The executive must be taught to diagnose himself as well as others and to make decisions and give orders as a joint effort. He said traditional programs are inadequate because people can't be shown how to handle others until they can evaluate and understand themselves and others.

He pointed out that individuals and companies don't spend enough time on the constant maintenance of human relations. Physical items such as machinery get a routine check for maintenance, but too often human relations are allowed to get rusty or break down.

Eugene E. Jennings, Ph.D., associate professor of Business Administration at Michigan State University, discussed the use of power politics in industry in his address to the closing general session, titled "Executive practices." He said a study showed that one of three executives uses power politics to achieve results. He gave four reasons for the use of power politics: 1. The job is a short term one or the individual is in it only a brief time. 2. Men are pushed ahead and resort to power politics to meet the demands of the situation. 3. Because of the changing nature of the executive role, decisions are now questioned and through politics one can give the impression of being democratic. 4. Sponsored proteges used to be taken in to be taught the job, but currently this relationship has changed into character manipulation, social graces, etc.

Dr. Jennings cited three conclusions which emerged from a research project into the use of politics: 1. People use politics because of a mixed sense of values. They are too ambitious for success. They compromise principles for success. Success becomes a Goddess. 2. Politics is used because of the psychological immaturity of the individual. He lets others decide how he should act. Actually it is more of a matter of reacting rather than fact deciding on one course of action. Individuals play power politics because they have a character that will compromise self-dignity. 3. More people are becoming more aware of the use of politics today, and in this manner of learning more about it. This is the best way of restricting the power politician by learning more about the superficialities of politics. ★

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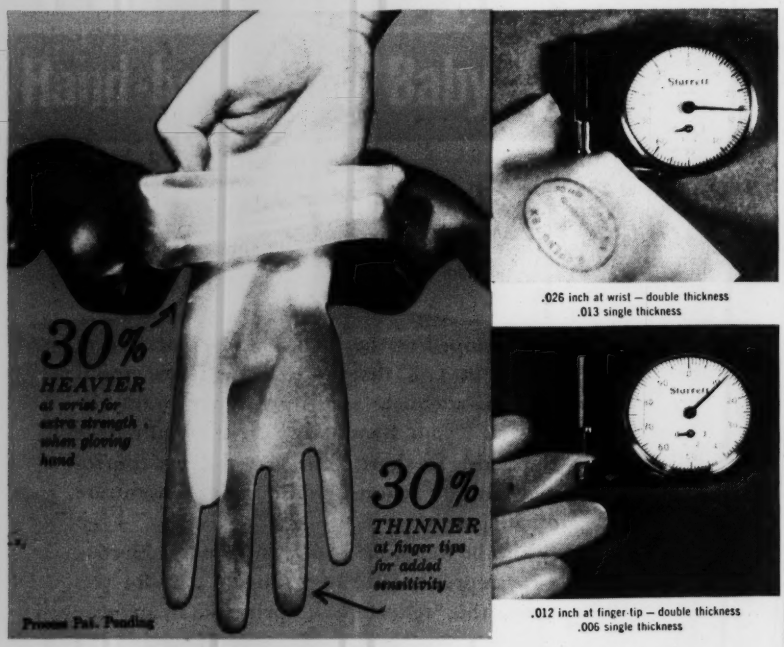

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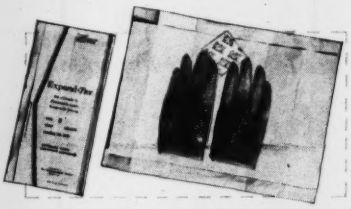

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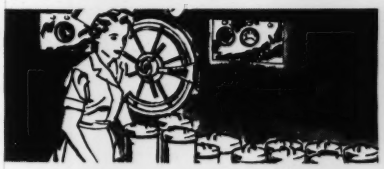

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NEWS

Child Center Treating Rheumatoid Arthritis

A treatment center for children with rheumatoid arthritis will be established at the Jersey City Medical Center in collaboration with the Seton Hall University College of Medicine, Jersey City, N.J. The center's program will be supervised by Drs. John Calabro and Harold Jaeghers of the Seton Hall faculty.

Described as the first of its kind in the country, the center was provided with a grant of $26,498 for the first-year operating costs by chapters of the National Foundation in Hudson, Essex and Bergen counties. The funds will take care of patients' hospital costs at the rate of $20 a day and the salaries of a physical therapist and a medical social worker at the center.

Monks Turn Medical Sleuths

Priests and brothers of St. Andrew Benedictine Abbey, Cleveland, Ohio, have turned "medical detectives," delving into the heart and circulatory system mysteries. They are helping Drs. Robert Edmands and Carroll Quinlan of the U.S. Public Health Service, who are trying to find out what causes hardening and narrowing of the arteries which lead to heart attacks and strokes.

The study was started with Trappist Monks near Conyers, Ga., and Benedictines in St. Bernard Abbey, Cullman, Ala., because Trappists don't eat meat while Benedictines have a diet like most Americans. In addition, the Benedictines live regulated lives, getting balanced amounts of sleep, exercise and so on.

Some 2,000 Trappists and Benedictines are under study. Researchers are going from monastery to monastery making blood, pressure and heart tests. Abbots will send reports of all illness of monks to the researchers.

Nuns Plan New Home for Aged

Franciscan Sisters are planning to construct a new home for the aged in Tiffin, Ohio, without benefit of a building fund drive. The sisters will mortgage their lands and buildings for the necessary funds to start building and will rely on contributions to see the project finished.

The sisterhood opened a home for the aged in 1867, the year when the community was founded. The home has accepted men and women who are 65 and older. There are now 37 women and 45 men at the home—and a long waiting list. The women are quartered in additions built in 1879 and 1884.

Superior General Mother Miriam said the new building will have private room accommodations for 51 women and 10 suites with private baths for occupancy by married couples. The plans also include an infirmary over the chapel, a "drive in" confessional and shower for wheelchair residents. A wing to accommodate aged men will be built at a later date.

A.H.A. Announces Administrative Changes

Four administrative changes in the American Hospital Association have been announced by Dr. Edwin L. Crosby, director.

Edmond J. Lanigan, an assistant director of the association, assumed the duties of director of the department of central services. His duties include supervision of the library, personnel department, management of headquarters building and facilities for travel, housing and conventions. Dr. J. Allen Mahoney has been named acting director of the department of research and statistics and acting assistant director of the hospital research and educational trust. Dr. Ko Shih has been named statistician for the association and the hospital research and educational trust; Jack Owen has succeeded Mr. Lanigan as secretary of the A.H.A. council on association services.

DR. LOUIS BLOCK, formerly of the U.S.P.H.S., has joined the firm of Gordon Friesen Associates, Washington, D.C., hospital consultants.

Aged Care A Clergy Responsibility

Churches, synagogues and their clergy have a responsibility to help the aging solve their special problems, Msgr. Wilbur F. Suedkamp, Detroit, Mich., said. He termed the care of the aged "the greatest social work challenge today" in addressing a recent session sponsored by the southeastern region of the Michigan Nursing Home Association.

Msgr. Suedkamp said the clergy's responsibilities to the aged ill include the need for knowing the resources of a community to make proper referrals. He also called for an aggressive approach to counseling to seek out and find the older, harder-to-reach persons.

"I question whether we can take the family and youth and psychiatric centered principles of casework techniques and apply them without reservation to the field of social gerontology. We must specialize in social gerontology as we have in child welfare," he said.

Directing his attention to the senior citizens who attend the conference, the monsignor outlined areas of special concern to most older people: Assurance of God's continuing love and a firm spiritual grounding. 2. Certainty that life is protected by his fellow man. 3. Relief from guilt feelings, fear of illness and the process of death. 4. Isolation that comes with aging when a higher death rate removes friends. 5. A perspective enabling the aged to see their problems against the backdrop of God's Providence. 6. Continuing spiritual growth. 7. A satisfying status in life.

Voluntary Hospitals Charge Huge Welfare Loss

Voluntary hospitals have demanded New York City make up a $22 million annual loss which they say is incurred by their care of city welfare patients

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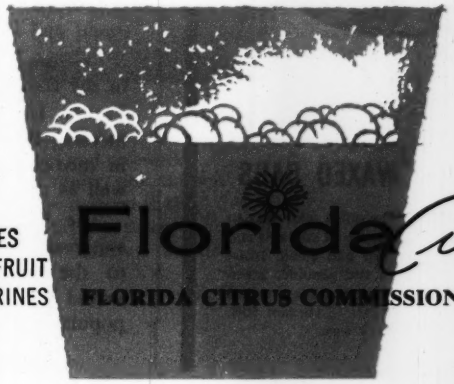
As a high-potency source of vitamin C, citrus juice—fresh, frozen, or canned—is unmatched for convenience and economy. The table below shows amounts† of other fruit juices required to supply the 100 mg.* of vitamin C in one glass (7-9 fl. oz.) of citrus juice.

citrus	1 glass
apple	50 glasses
grape	9 glasses
pineapple	3-4 glasses
prune	50 glasses

†Data calculated from: Watt, B. K. et al., U.S. Dept. Agric. Handbook No. 8, 1950; and Burger, M. et al. Agr. & Food Chem. 4:418, 1956.

*This is the peak of the Recommended Daily Allowances for adolescence or pregnancy; 150 mg. during lactation; 70-75 mg. for normal adults.



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at less than cost. In the meantime, the United Hospital Fund said 15 voluntary hospitals may have to close for financial reasons. These 15 and seven others cannot meet their bills. The report, charging a big loss by the private hospitals, was presented to Mayor Robert Wagner, Jr., by the Hospital Trustees Committee, the New York Archdiocesan Catholic Charities, the Federation of Jewish Philanthropies and the Federation of Protestant Welfare Agencies.

The report said that because the city does not pay enough for care of welfare patients, the voluntary hospitals have suffered a loss of $185,000,000 since World War II.

Captain Stone Retires

Captain J. E. Stone, C.B.E., M.C., F.S.A.A., F.H.A., has retired from the post of honorary secretary and treasurer of the International Hospital Federation, London, England, a post which he had held for 11 years.

He is succeeded by Dr. J. C. J. Burkens, medical director of the Oude en Nieuwe Gasthuis in Delft, Netherlands, who has been a member of the Federations Council of Management since 1955. The secretariat of the federation is at 34 King Street, London E. C. 2, England.

Grant to American College of Surgeons

A grant of $146,275 by the John A. Hartford Foundation, Inc., of New York, to the American College of Surgeons to inaugurate a program for improving the medical management of the surgical and injured patient was announced recently by Ralph W. Burger, president of the foundation and Dr. I. S. Ravdin, chairman of the board of regents of the college.

The new program will permit immediate establishment of pilot projects in selected cities, employment of a field staff to provide personal guidance both to the public and the profession throughout America, and initiation of an evaluation program—all with the primary goal of improving care of the surgical and injured patient. The College's current efforts in the field will be implemented by the grant in the following problem area programs: effective safe transportation of the injured, first aid and self aid, organization and staffing of the several elements of hospitals involved in emergency medical care of the injured, demands caused by disasters and education of the medical profession in the management of trauma at the undergraduate and graduate levels.

Asian Doctors Push Food Production

Dr. Paulino Garcia, chairman of the national science development board of the Philippines, told the first Asian congress of Catholic physicians that solutions to the world's overpopulation problem based on artificial birth control, sterilization or abortion are immoral and impractical.

Doctors from 14 countries took part in the congress held recently at Santo Tomas University in Manila. The meeting discussed Catholic principles in medical practice and education as well as the population problem.

The Asian doctors resolved at their congress: 1) That a practical solution to the problems of overpopulation would be a better distribution of population throughout the world. 2)

(Continued on page 48)

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TRENDS In Patient Room Furnishings

Save Valuable Floor Space—Achieve New and Distinctive Effects in Interior Design.

Hospitals, like people, assume a certain distinctive character or individuality which can be favorable or unfavorable from the viewpoint of the public.

Many hospitals have found that a slightly out-of-focus image can be corrected by *creative* equipment selection and arrangement, embodying the best principles of modern interior design.

Custom-designing An Impression. The most lasting memories impressed upon the mind of patient or public are visual. The apparent size of the room, its drapes, furniture, walls, etc. These are things that can be controlled from start to finish, as many hospitals have learned; and, by this means, the exact impression they wish to make upon public, patient and their own staff alike is likewise controlled.

Equipment—Important Element of Design. Equipment selection and arrangement is the most important means of creating hospital interiors of outstanding distinction and merit. Our new Valette, for example, is often selected because it eliminates the old wardrobe that occupied so much floor space, as well as the large, old-fashioned dresser. The patient is both amazed and pleased that his entire belongings can be kept together at his bedside along with the usual hospital utensils, etc.

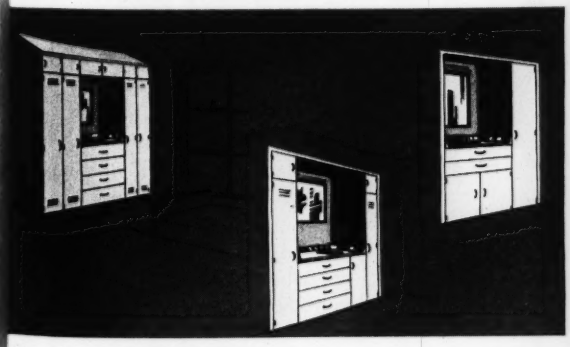
The Queen of Angels Hi-Low Bedside Cabinet is another excellent example of equipment designed to save space, yet embody the functional convenience that nurses and patients appreciate so much.

Color and Texture. Color and Texture are the most important tools used by the interior designer in establishing the all-important esthetic values which are receiving more and more attention in modern planning. These are inescapable, and must be dealt with wherever they are found in equipment, floor, walls, drapes and accessory items. They can be changed or altered without limit, but decisions must be made.

Selection and arrangement of colors and textures should be left to those experienced in this field, if the most desirable results are to be expected. This is, in fact, a specialized field in itself.

Let Aloe Help You Plan. Aloe Equipment Planning and Interior Design Department is staffed by consultants experienced in all aspects of interior design and are available to assist you at all times. Our planning staff is prepared to suggest equipment lists and work directly with you in achieving custom-type interiors suitable to your hospital alone.

Write or see your Aloe Representative for complete details.



Eliminate loose furniture and old-fashioned sinks with these custom-built wardrobes and casework units, which combine wardrobe, vanity, sink, dresser, lockers and linen storage. May be recessed in the wall. Available for private, semi-private, three- or four-bed rooms. Select any part or complete facilities.

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(Continued from page 44)

That artificial means of controlling population should be replaced with technological and productive efforts to cope with the needs of population pressures. 3) That there should be at least one Catholic medical school in every country and that in the absence of such schools, scholarships should be made available. 4) That Catholic medical literature should be distributed in Asian countries without Catholic medical schools. 5) That legislation should be considered to outlaw such practices as abortion, sterilization, artificial insemination and euthanasia. 6) That the practice of the rhythm method of birth control, though permissible in individual cases, may not be endorsed by a government in meeting the problem of overpopulation.

Dr. Antonio O. Gisbert of the Philippines said the medical profession should never allow itself to be used as a tool in artifically controlling population. "In the last analysis" he said, "overpopulation should be considered merely as over-concentration of populations: a definite challenge to the 'have' nations to help their less fortunate neighbors."

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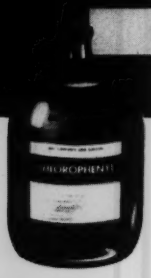

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Griffenhagen New A.Ph.A. *Journal* M.E.

Dr. William S. Apple, newly elected secretary and general manager of the American Pharmaceutical Association, recently appointed George B. Griffenhagen, Washington, D.C., to be director of communications and managing editor of the A.Ph.A. *Journal*. Mr. Griffenhagen had been appointed secretary of the association's public relations committee in July. He has served as deputy director and coördinator of convention activities for the association during the past two years.

The newly established post of director of the division of communications includes administrative responsibility for the public relations program (including National Pharmacy Week), convention activities and the association's library and museum.

Mr. Griffenhagen formerly served as curator of the Division of Medical Sciences at the Smithsonian Institute and as an officer of the association's section on historical pharmacy.

Committee Offers Plan to Appraise Care

A committee of the American College of Physicians has developed a plan by which the quality of practice of internal medicine in hospitals of this country can be appraised. Their project was made possible by grants by the American College of Physicians and the National Institute of Health. It was concluded that the evaluation of hospital records should be done by physicians who are internists. Hospital staffs will have to assess the quality of their own work.

The plan was developed after three years of field work. It calls for the organization of a hospital appraisal committee, chosen from members of the staff who practice internal medicine or allied specialties. This group should judge the performance of its colleagues —not seek out instances of mismanagement, or discipline staff members— to promote standards which will benefit every member. The work of the committee serves as a basis for general discussion regarding standards. Staff education and resulting improvement in care of patients are the most

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desirable consequences with disciplinary action, if needed, left to the executive committee of the staff.

The report made for each record reviewed would be kept confidential and shou!d not be filed with the record. It should be available only to the appraisal committee and the executive committee of the staff.

Three reasons for a comprehensive study of standards of hospital practice in internal medicine are the increasing number of internists in practice, increase in their usage of hospitals and an urgent need to judge the quality of medical practice. This can be done by a study of a variety of patients' records. It can be accomplished by judging 20 per cent of a month's medical admissions to the hospital. The records of all medical patients who died during that month should be added. It is desirable to evaluate records from different disease categories each month, bearing in mind that some records of every staff member who practices internal medicine should be examined at least once a year.

It was encouraging to learn that in 118 of 214 hospitals chosen for study, the staffs were endeavoring to elevate their standards of internal medicine by study of the records in their own hospitals.

Requests for further information should be forwarded to the national office of the American College of Physicians, 4200 Pine St., Philadelphia 4, Pa.

Maryknollers Report 1959 Activities

More than a half-million patients were treated during the past year in clinics staffed by Maryknoll Sisters on four continents, the community's report for 1959 reveals. In addition 13 projects were initiated during the year, ranging from a hospital in Hong Kong to a catechetical house in northern Japan and a new school in Hawaii.

Medically trained sisters took care of 27,944 patients in hospitals in the Philippines, Ceylon, California and Bolivia. They treated 583,997 patients in clinics and made 3,942 medical home visits. In Hong Kong, ground was broken for a new hospital where the sisters will help care for the thousands of refugees who have streamed into the city from Red China.

There are now 1,350 Maryknoll Sisters. The 39-year-old mission congregation has a total of 1,450 members. These include novices and postulants.

Source Book Lists Health Insurance Data

The American public spent an average of $95 a person for medical care in 1958, the Health Insurance Institute reported recently in its new publication, *Source Book of Health Insurance Data.* Total public expenditures for personal medical care in 1958 were $16.7 billion, comprising nearly six per cent of the public's outlay for all its personal needs.

Hospitals accounted for $4.5 billion of the total, doctors for $4.8 billion, dentists for $1.7 billion, drugs, medicines and orthopedic appliances for $4.4 billion. The remaining $1.3 billion went for all other medical costs, including private duty nurses, nursing homes, chiropractors, eyeglasses and the expenses of insurance.

The Source Book, first of its kind in

(Continued on page 58)

HERE'S MORE

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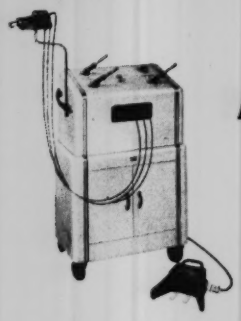

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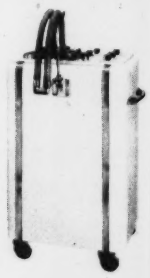

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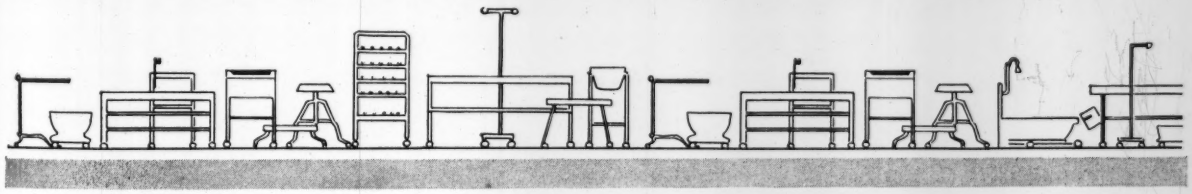

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So important, in fact, is the need for asepsis that it has become a prime factor in the selection of equipment for the operating room, the nursery, and every department of the hospital. And with good reason: hard-to-clean surfaces, cracks and crevices found in ordinary equipment can defeat even the most carefully planned asepsis program.

Blickman equipment, however, is predicated on the need for easy and complete sterilization. All the advantages of stainless steel are utilized by Blickman to counter the spread of bacteria. Extremely fine finishes, for example, prevent germ-collecting stains and corrosion. Rounded corners... invisible seamless welds... completely crevice-free surfaces and joints—provide little room for staphylococcus to hide and escape disinfection. And in addition, Blickman's rugged construction assures you *decades of durability at no extra cost.* For complete details, write for catalog #6195: S. Blickman, Inc., 1703 Gregory Ave., Weehawken, N. J.

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the health insurance field, is a comprehensive compilation of statistical and other factual material related to health insurance and the financing of medical care. The information was drawn from several insurance associations, other health insuring plans, government agencies, as well as hospital and medical groups.

The 80-page book contains 11 charts, 32 tables, a glossary of health insurance terminology and a list of historic dates in the health insurance field.

Some of the subjects relating to health insurance in the book are health insurance during 1958, extent of insurance coverage, trends in premiums and benefits, types of health insuring organizations, medical care costs and morbidity in the United States.

Guild to Assist Hansen's Disease Victims

The New Orleans Carville Guild has been organized in New Orleans, La., with 36 members. The group will work for the benefit of the 187 patients of Hansen's disease at Carville Hospital.

Archbishop Joseph F. Rummel of New Orleans is honorary president, Sister Alfonsa, D.C., stationed at the U.S. Government hospital, is honorary vice-president and Father Alcuin Kammer, O.F.M., hospital chaplain, is spiritual director.

Legislature Praises Michigan Hospitals

In a concurrent resolution the Michigan State Legislature highly commended Michigan hospitals for uniting in a search to find ways to bring about economies and improvements in hospital operations.

The resolution praised the Michigan Hospital Association and the Michigan Blue Cross for their joint sponsorship of the Annual Hospital Achievements Contest, the objectives of which are "to obtain from hospitals the best money-saving ideas and methods for streamlining operational efficiency."

The Hospital Achievements Contest —sponsored jointly by the Michigan Hospital Association and its officially approved prepayment plan, Michigan Blue Cross — annually offers cash awards totaling $4,000 for the best ideas developed by hospital employes to improve patient care and save money for more efficient operations.

A total of 231 entries marked the 1959 competition and all have been compiled in a 200-page manual distributed to all 226 M.H.A. member hospitals. "This is one of the major aims of the competition," A. Kent Schafer, Michigan Hospital Association president explained. "It gives all of our hospitals a chance to study and if feasible, put into effect the improvements developed by others."

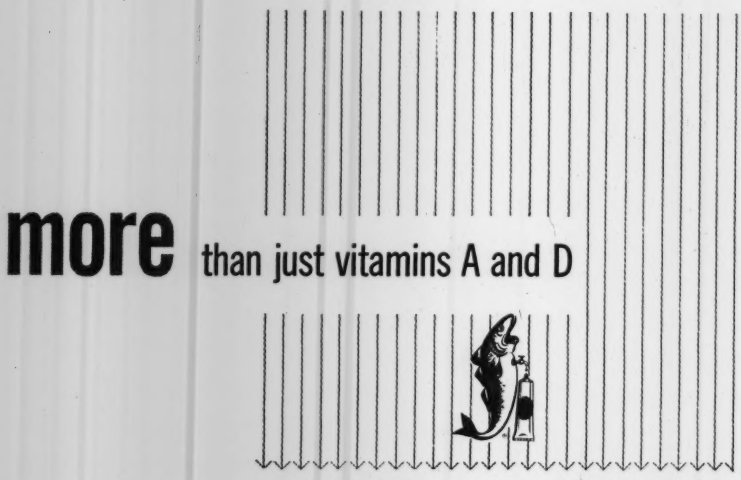
The manual may be obtained from the Michigan Hospital Association at a cost of $6.14, which includes postage.

Doctor Will Do Medical Mission Work in Africa

Dr. Joachim Gfoeller of Cleveland, together with his wife and three children, left recently for Berekum, Ghana, where he will join the staff of the Holy Family Hospital, conducted by the Medical Mission Sisters of Philadelphia.

Dr. Gfoeller, a radiologist will work with Sister Mary Gregory, M.D., on the staff of the 110 bed hospital which cares for the people of the northwest cocoa farms of Ghana.

Sister Jude Marie Garbaccio, a nurse of Montclair, N.J., has also been assigned to Berekum and accompanied the Gfoellers on their trip. ★



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Planning Means Success

EMPHASIS IS DIRECTED in this issue of HOSPITAL PROGRESS to hospital construction. Traditional concepts have too long governed the decisions of administrators and boards—even architects. Tradition enriches the practice of faith and gives substance and fiber to the mores of peoples. It may stifle initiative and imagination in hospital planning and construction. Hospitals are institutions where doctors practice medicine, and the face of medicine has changed radically in the past two or three decades. Research and the exigencies of two global wars have added the initial "R" to the *evolution* of medicine. Change follows change so rapidly that one cannot but sympathize with hospital administrators who despair of ever keeping abreast of shifting patterns of care.

We cannot, however, let despair deter us from constant effort toward improvement. We can neither cling to the comfortably sturdy staff of tradition nor (should we) plunge headlong into change merely for the sake of change. Survey, evaluation, planning, programming and reliance on the best consultative help available are the tools which will enable hospital administration to meet the multiple challenges of this era. Dr. Rourke says at the conclusion of his excellent article in this issue that administrators and trustees cannot sit back any longer and "let Jack do it." In a different context in another fine article Roy Hudenburg cautions against the "Let's see how George did it" approach to planning. In an entertaining bit of whimsy, Charles Berry *almost* gently spoofs the visionaries and extreme pragmatists for whom automation is both the means and the end.

In major construction, such as the building of a complete new physical plant, the administrator must be willing and able to devote many hours of each day, for months on end, to the primary purpose of planning, checking, ever questioning and revising, consulting and *listening* with an open mind to the advice and counsels of those whose talents, experience and vision equip them to advise in a given area. It is always more difficult to make a decision than to follow the crowd. The wise administrator seeks the help; solicits the opinion of perhaps hundreds of individuals; but the mind of the administrator is the scale in which all these are weighed, and the administrator's wisdom and common sense are the balance on the left side of the scale.

Decision in design may necessitate changes in certain functions and procedures. While an administrator must have overcome personal resistance to change to make these decisions, there remains a further job of selling and education to be done. If alteration is required in time-honored practices and habits of the medical staff, the staff must be *sold* on the wisdom and utility of the innovations. This can be done if medical staff committees have been consulted during the initial course of planning. Personnel of various service departments may have to be re-educated to new patterns of performance. If the administrator is personally convinced that the *why* for these innovations is valid, the inducement to change the *how* will be conveyed more easily and reasonably.

No less demanding is the task of renovating an existing facility or attempting to expand it functionally to meet urgent demands of increased occupancy or services. In building a new hospital an administrator must keep in mind that she bequeaths her mistakes to a long line of successors: In attempting to renovate or expand an old plant she realizes that she has inherited, if not ancient mistakes, facilities that are tragic victims of progress. And the administrator "saddled" with this job will find that it is even more difficult to "sell" or re-educate her doctors, nurses and other personnel than it would be in an entirely new facility. It's not entirely true that "You can't teach an old dog new tricks," but adaptation is at least easier in a new than in an old kennel.

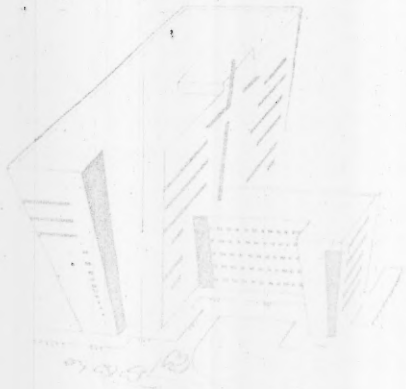
Again, survey, honest evaluation, planning programming and the wise use of competent consultants are the tools on which the administrator must rely.

What does all this mean? Does it mean that administrators have been "all wrong" in the construction and maintenance of their hospitals in the past—that nothing of the old can survive or complement the new? Does it mean that the vast complex of the Catholic hospital system is, or is in danger of becoming, a dusty memorial to a glorious past that has no relation to the present and can have little effect on the future? It means none of these, certainly.

What it does mean is that some of the same problems that confronted pioneer sisters and brothers repeat themselves to challenge their successors. We sometimes invest their heroic lives with an aura of glamor or romance with which all peoples are apt to cloak the struggles or triumphs of history. Their struggles, however, were against very ordinary, practical problems of finance, space, personnel and facilities. Their triumph is the Catholic hospital system of today. Progress, research and refinement have contrived to pose again to that system the problems of its founders. Their testament is the inspiration which will enable modern administrators to pick up the gauntlet of the future. ★

construction

Tomorrow's Hospital*



by **ANTHONY J. J. ROURKE, M.D.**
Hospital Consultant
New Rochelle, N. Y.

ONE MIGHT EXPECT, from the title, to read about special units in the general hospital for the care of people from outer space; electronic gadgets for determining the diagnosis, writing the medical record and prescribing the treatment; or concentrated food for the hospital stay stored in a small compartment of the night stand. But alas, my crystal ball isn't clear enough to see all the future, so I must confine my remarks to what I think some future trends may be.

The Changing Nature of the Hospital

■ At the turn of the century the American hospital was a truly charitable, fairly well-endowed institution, operated with unskilled, poorly paid labor, with a loosely knit medical staff, a minimum of simple diagnostic tools and a few wonder drugs, including castor oil, camphor and cascara.

As we approach the seventh decade of this century the American hospital is a not-for-profit, extremely poorly endowed institution, operated with better educated and more skilled workers who receive more nearly a living wage and a highly organized medical staff, which has at its command many intricate diagnostic devices and wonder drugs, including tranquilizers, agitators and antibiotics.

The general hospital of 60 years ago was incorrectly named for it did not admit patients with tuberculosis, communicable diseases, psychoses, alcoholism, or venereal diseases—nor was it associated with home care programs, ambulatory diagnostic services or extensive outpatient centers.

In the present general hospital, thanks to medication which renders the sputum of tuberculosis patients negative, more and more such patients are admitted; thanks to the tranquilizers which have made the psychotic patients manageable, more and more are being admitted; thanks to the antibiotics and chemotherapeutics, patients with communicable diseases are treated at home or in the general hospital; and thanks to perhaps one of the very few benefits of the last great war, the development of rehabilitation techniques has brought the chronic patients into the orbit of the general hospital.

If as many changes occur in the next 60 years as have in the past 60, trustees and administrators will be hard put to adapt to such progress. What are a few of the changes which may lie ahead?

Size of the Nursing Unit

■ Nursing units of 30 beds will, and should, give way soon to more economical and better supervised units of nearer 60 beds. Several factors have delayed this necessary change.

1. The traditional, single-corridor, rectangular building did not allow arrangement of all beds within 90 feet of a nursing station, thus making larger units impractical.

2. Nurses have, incorrectly, felt that the use of larger units was a method of making the same number of nurses care for twice as many patients.

3. Using the full potential of a central sterile supply room, with vertical elements for transportation, was not conceived.

4. The lack of toilet facilities for each patient room prevented more convenient patient care.

5. The development of executive talent in head nurse personnel had made little or no progress by the time World War II struck a body blow that delayed progress at least 15 years.

6. Shorter nursing hours, straight shifts, five-day weeks and nurse shortages made us feel more secure in smaller units.

*A paper given Oct. 19, 1959 at The Institute of Hospital Planning sponsored by The Hospital Association of Pennsylvania at Bedford Springs, Pa.

Some of the advances in hospital evolution which will make enlarged units possible include: 1. Bathrooms with all patient rooms. 2. Intercommunication systems. 3. Intensive care units. 4. Postanesthetic recovery rooms. 5. Research in new building shapes to bring the periphery closer to the nursing station (double corridor, square, round, etc.). 6. Increased executive ability and managerial know-how as a result of new educational approaches in the nursing field. 7. Centralized food service. 8. Mechanical devices for transporting supplies, messages, trays, etc.

With larger nursing units we will achieve:

1. Lower buildings, with resulting savings in elevators, plumbing, heating pipes, stairwells, dumbwaiters, pneumatic tubes, trayveyors, etc.

2. The development of true managerial talent in the head nurse, by necessity, because she can no longer (nor will she need to) give bed baths, fill in for the absentee and help with surgical dressings.

3. Better use of such space as the conference room, examination and treatment room, public toilets, storage closets, solaria, medication alcoves, etc.

4. A reduction in the number of units in the hospital organization, thus reducing the number of managers, with increasing success in conference techniques, communication, delegation and followup.

5. A reduction in the impact of a "no-show" employe at the eleventh hour on a larger unit with eight workers over that on a smaller unit with four workers.

6. A flexibility which allows daytime operation as two divisions of the unit, while at night it can be one divison of optimum size.

7. An optimum volume of work which adequately warrants the use of a clerical worker in the nurses' station as part of the nursing team.

8. A reduction in the number of stops for pick-ups and deliveries by stores, pharmacy and others.

9. A reduction in the number of medicine units, linen rooms and nursing stations, where supplies and materials are stored and control and inventories are needed.

10. An improved elevator service with fewer floors and a shorter run.

11. Fewer stops for doctors when making rounds to private patients.

12. An improved nursing program, where *supervision* means availability for consultation, orientation and representation, not a circulating nurse to fill in for days off, illness and emergency loads.

Nursing units are already very hesitatingly creeping up from 30 to 36 to 40 to 44 beds. The eventual size has only the limitation of architectural imagination and ability in designing units with a span from station to periphery of not more than 90 feet and wings far enough apart so that they do not look like the spokes in a wheel.

Nurses must be assured that the optimum number of nursing hours per patient day will be supplied, regardless of size of the unit. They must be acquainted with the advantages of night shifts large enough to have more than the lonely solitary nurse of the present small unit.

As planners create the optimum unit of bricks and mortar, administration and nursing will create the organization to staff it for better service to the patients.

The day of the country store in hospital nursing units will give way to supermarket techniques. Like the supermarkets, the grade of hospital care will improve as has the grade of milk and meat and canned food. The beltline parts of the larger units will remain behind the scenes and the patient's immediate environment will remain the area of personal service, improved by better heating, ventilation, air-conditioning, fenestration, toilet, size of room and a resulting better service. He will be unaware of the improved management resulting from increased volume.

Width of Room

■ Orange juice, better living standards or something has caused the present generation to grow taller. In turn, hospital beds grow longer and longer. The eight-foot bed is not unusual. Unfortunately, many designers have kept both eyes on a budget—rather than one eye on function—and the width of the hospital room has not grown to keep up with the patient needs. The 10-foot or 10-foot, 6-inch room is not satisfactory and the needs will soon set the width at least at 12 feet.

Comfort

■ We dislike to have our hospitals compared with hotels, but the patient, while he may not appreciate the reason for different rates, does unconsciously (or consciously) desire all the comforts of hotel living. As long as economics and employment remain in satisfactory condition, hospitals will continue to build in more comfort items. Perhaps in many instances these comforts may truly be considered therapy.

Complete air-conditioning will be a must in future hospitals—not regular institutional air-conditioning—but systems without noise, without draft, with individual room control, with protection by filters against transfer of bacteria and (in certain areas) a ban against recirculation of air.

As the large open ward gives way to the more private four-bed ward, there now seems to be great interest in having two-bed units replace all four-bed units. In some areas the small single room has been created, with the corner bed, to give complete privacy.

Patient space will continue to add all comforts possible, such as the electric bed, telephone, radio, television and intercommunicating systems. Carpets are being used in hospital corridors and illumination is constantly undergoing change. For patients to use a common nursing floor toilet would seem to be too old fashioned for new hospitals. The next comfort added for patient use will be a shower in each toilet room adjacent to the patient's room. We are a nation of people who have developed a taste for the convenient and the modern. We have it at home and we seem to want it when we travel and when we are hospitalized.

One-Man Planners

■ Future hospitals will not be memorials to the one man who controlled the period in which they were built. The squeaking wheel of the future in our field will get the gate and not the grease. More emphasis will be placed on the balanced hospital—balanced in services, balanced in space and balanced in future potential.

I have yet to find the surgeon who felt that there could ever be too small a department of radiology and in turn a radiologist who felt that the operating suite could

be too small. Building of hospitals, with restricted capital funds, must always be a case of magnificent concessions. The effort to remain in balance will come only through the magnificent efforts of interested parties, rather than the capture of territory by aggressive individuals for selfish ends.

More and more time and emphasis should be given to research in design and function. Must all our planning be done by the vendors of equipment? Each specialist in the hospital, be he or she a dietitian or dermatologist, social worker or surgeon, nurse or neurologist, can and should contribute to planning the hospital of tomorrow.

Future planning will tend to pinpoint, and greater emphasis will be placed on, departmental studies, in place of the broadside approach of the past two decades. This is readily appreciated when one develops a check list for one of the smallest units of a hospital—the patient's bathroom. Let's run through a list of items to be considered:

1. Type of flooring.
2. Type of cove.
3. Type of walls—height of tile.
4. Type of wall above tile.
5. Type of ceiling.
6. Type of lights.
7. Ventilation.
8. Wall-hung or floor mounted toilet.
9. Bedpan washing device—type of pedal, hose, nozzle, pipe, etc., with hot and/or cold water.
10. Height of lavatory from floor. Gooseneck spout, faucet handles. Located in toilet or patient's room.
11. Emergency call bell.
12. Grab bars.
13. Medicine cabinet—or mirror—shelf.
14. Outlets for electric razors.
15. Hook for dressing gown.
16. Cabinet for bedpans—or not.
17. Toilet tissue holder.
18. Facial tissue holder.
19. Towel bars—number, location.
20. Type of toilet seat.
21. Door to swing in, out or both ways. Doorstop—hardware—door sill.
22. Location of fixtures.
23. Waste receptacle—built-in or portable.

As one reviews the 23 areas above presented for decision, it is simple to envision the magnitude of the task of planning x-ray departments, operating rooms, laboratories or kitchens. Planning is slowly, but gradually, becoming specialized in form and function.

The Unorthodox

■ The gray flannel suit of Madison Avenue has its counterpart in hospital construction. Attention-getting devices will continue to receive the attention of some segments of our field. Change for the sake of change is nonsense. Change in building merely to attract attention is a form of sheer institutional exhibitionism. Change that breaks with convention in finding better solutions to perennial problems makes common sense.

Open balconies in a windy, foggy city, glass walls without air-conditioning or light control, decorations to simulate night clubs and stairways suspended by metal threads do much for designers and hospital people with a flair for publicity. They do little for the functional improvement of the hospital or reduction of the cost of patient care. That which is pleasing to the eye has a real place in this drab world of ours, but only as frosting on the cake and not in place of the cake itself.

The future will see many attempts to attract attention, but I am sure it will be protected by hospital people with their feet on the ground.

Cancer

■ Most of us have lived to see the marked decline in the need for pediatric beds with the increase in the care of the child at home or in the doctor's office. Mastoiditis and osteomyelitis have nearly disappeared. Pneumonia with lung abscess as a complication is seldom seen. The great Trudeau Sanitorium for tuberculosis no longer cares for the sick, while the world-famous Willard Parker Communicable Disease Hospital no longer knows the sound of whooping cough or stocks the tubes for tracheotomies associated with diphtheria. In fact, its doors are closed. Syphilis and erysipelas are rare terms in hospital language today. Real hope exists that poliomyelitis may before long be only a term in a medical textbook.

Each of the above took beds and hospital facilities. As they disappeared, changing times took up the space with heart surgery, lung surgery and surgery of the older person. Prepayment resulted in more and more people receiving the care they had neglected in previous years. As a result, we felt little of the loss of the patients who no longer appear in our hospitals with diseases which have been conquered.

But what will happen if the Good Lord, in His wisdom, allows medical scientists to unlock the secret of the uncontrolled cellular division which is cancer. In the light of the history of the years and years spent in research on tuberculosis, communicable disease, heart surgery and the virus diseases, it would not seem unreasonable to hope that in our lifetime cancer will be successfully conquered, one type at a time.

Such reflections should motivate the hospital builders to plan conservatively and for flexibility. How many beds are today occupied with patients suffering from cancer or suspected cancer? How many hours of laboratory work, x-ray work or surgery time are consumed in this field? And yet, are these thoughts too far-fetched, when one realizes that we have not increased pediatric beds since World War II in spite of the great increase in the birth rate?

Additions and Subtractions

■ The past decade has seen the addition of intensive care units, progressive patient care units, cardiopulmonary laboratories, postanesthetic recovery rooms, postpartum recovery units, maximum security rooms in the general hospital (for care of psychotic patients) rehabilitation units and headquarters for home care.

The emergency room now cares for many patients formerly seen in doctors' offices. The doctor's office draws closer and closer to the hospital, while his splints, casts, dressings and injections move over to the emergency service.

While new functions move in, certain traditional

hospital functions move out. Bottled infant formula is delivered to the hospital, linen is processed by the commercial laundry, window washing and pest extermination services are contracted for, food service is operated by outside agencies (and in some cases the food is prepared outside the hospital). Banks have contracted to handle hospital payrolls. Hospitals rent luers and needles. Central tabulating services are available. Group purchasing and pharmacy services are supplied by other commercial firms.

It is interesting to note that the new functions acquired are in almost every instance directly related to patient care, while those given up are nearly all service functions, only indirectly related to patient care. This may mean that the hospital of the future will specialize in the areas of direct care and may farm out other services. This will, of course, alter the need for space.

Economics

■ The coin of the realm will have a great impact on the hospital buildings of the future. With salaries taking 65 to 70 per cent of the hospital budget, representing about two full-time workers for every occupied bed, it is no longer possible to depend on shank's mare if metallic automation can be substituted. There is every reason to believe that union activities will not lower personnel costs or numbers; and so, to hold the line and do a better job, we will look to mechanical devices to transport supplies, add up bills, count blood cells, wash, rinse and extract laundry, shake and fold sheets, convey trays while they are assembled, lower and raise your beds, wash dishes, develop x-ray film in a few minutes and do the accounting.

Hospitals without every bit of time and labor saving equipment possible will find it hard to keep afloat.

Diagnostic Tools

■ The past decade has seen tremendous increases in the use of the laboratory and x-ray facilities. Prior to the last great war we were all confident that use of these diagnostic tools was being neglected. In some areas this is still true. The demands for space in these two departments continue to increase as the cost of their services also increases.

Let us pause for a moment and review the history of the appendectomy. In early years thousands died as the result of ruptured appendices, because few knew how to make a diagnosis, fewer still knew the surgical techniques necessary and operations were avoided. Then many learned how to operate and before long many surgeons could take out healthy appendices as well as diseased ones. As a result, medical schools, the College of Surgeons, the Joint Commission on Accreditation of Hospitals and the profession focused attention on unnecessary surgery, with the result that there has been a marked reduction in the number of appendectomies.

Let us now go back to the use of the laboratory and x-ray. No one wants to deprive any doctor or patient of any diagnostic test which is justified or needed; but should we not ask ourselves whether there is any danger that the history of the appendectomy is being repeated?

The field of medicine will soon have to study the use, or possible abuse, of the laboratory and x-ray. Without some worthwhile studies, the planner doesn't know whether he is building for real need or fancy. Unlike the unnecessary surgery, in which only the surgeon is involved, the Pathologist and Radiologist must supply the laboratory and radiology services requested by the patient's physician whether it is justified or unjustified.

This area should be explored gently in the years ahead and may result in some better criteria for space. As a result many small hospitals will probably realize that their laboratory and x-ray services are far below normal and the large hospital may learn that better guide posts are needed, especially in the introduction of the intern and resident to the use of these services.

The next decade should reveal what our future pattern will be in the use of laboratory and radiology services by private referred ambulatory patients, or there will be a duplication of community facilities.

Miscellaneous

■ Tomorrow's hospital has many problems before it, each deserving a separate paper. How the problems are solved will determine space needs and departmental relationships. Planning has often suffered because the administrator has tried to do the planning and at the same time run the hospital. In many instances he has done neither job well. Many boards are beginning to realize the ineffectiveness of this approach. They are getting help to administer while the administrator plans, or to help in planning while the administrator operates the hospital and sits at the summit during decision making on the new building.

The problems which cannot be solved by knowing material strengths, boiler capacities and weight loads are staggering in number. They must be attacked within the profession of hospital operation and presented to the architect for clothing. To mention but a few:

1. *Hospital Infection*—Ventilation hazards, cross-traffic in laundries—newborn nursery hazards—hazards in the operating and delivery suites.

2. *Tuberculosis*—Patients dying from this disease have decreased, but the number of patients contracting the disease will continue to present a major problem. Will they eventually all be admitted to the general hospital and, if so, will they be intermingled with medical patients or be assigned to separate floors or units?

3. *Psychiatry*—The fast pace of the present, with its accompanying tensions, has increased the number of psychotic and neurotic patients. The total census in our state mental institutions has declined for the past three years for the first time in history. Does our vision at least encompass sufficient land for the possible concept of the new general hospital which has reached its full potential, including the care of psychiatric patients?

4. *Chronic Care*—The chronic disease patient isolated from the medical center atmosphere, deprived of the psychiatrist, his team and his tools, will continue to cry for help until the general hospital makes provision to receive this group.

5. *Sick Aged*—Increased longevity has raised the average age of the hospitalized patient. All too frequently the aged are seen as chronic disease patients. This is often far from the case. Many well aged suffer episodes of acute illness needing hospital care. New preoperative techniques, better anesthesia and advances in surgery make care of these people a rewarding experience. As the cen-

tury progresses, will the number of such people increase enough to appreciably affect the hospital census? If the number increases, would these patients be happier grouped in their own unit in the general hospital or should they be intermingled?

6. *Prepayment*—This is an area which will affect the hospital of tomorrow more than any other one factor. Will there continue to be some coverage that pays only when the patient is in the hospital? Can they and we stem the tide of unnecessary admissions—and excessive hospital stays? Will prepayment groups succeed in seizing control of the destiny of the general hospital? Can man-made shortages of beds, stimulated by prepayment groups, be accepted as the answer, or do they attack the problems of over-utilization and high costs by public education and physician education, while we attack it with tighter management and more functional buildings? Planning tomorrow's hospital must consider the pattern of tomorrow's coverage.

7. *Automation*—How can we automate the tender loving care we need for our patients? We can't, but beyond the nurse at the bedside, every possible bit of automation must be included. Increased salaries, increased numbers of employes and increased unionization will make automation a must. Time does not permit listing all areas, but vertical transportation cores, gravity chutes, centralization with transportation on expertly designed carriers and doctor dictation from any spot where a telephone is located as well as from his own office are merely illustrations of what will become the accepted pattern. Better personnel recruitment, selection, supervision and *better termination* will be standard procedures and new buildings must provide the necessary space.

8. *Departmental Relationships*—Studies of function related to personnel needs and clinical safety must be carried out by hospital trained people. What is the proper relationship of the doctors' coatroom, the medical record room and the medical library; of emergency, x-ray, operating room and laboratory; of the kitchen, dishwashing room, dining rooms, cafeteria and vertical transporation; of the delivery rooms, labor rooms, maternity patient rooms, nurseries and father's room? Who said the last word has already been written in these areas of relationship?

9. *The Old and the New*—The future will give us more clearly defined guide lines regarding new additions to old structures. Today they rest on personal judgment without agreement in the field and sometimes are decided by impulsive and powerful men who get their knowledge by revelation and not by education in the field. Somewhere along the line *before tomorrow* we must develop acceptable criteria for determining when to follow old floor levels, when to break from existing levels and ramp or when to build a detached structure with tunnel connection only.

10. *Research*—"Everyone talks about it and few do anything about it" is the usual wheeze. This is no longer true, for we are starting a number of worthwhile projects. We are fast getting away from implicit belief in the word of the great surgeon, the great administrator, or the great nursing director and are taking our research back to the trenches where the workers can give first-hand impressions on the ground. In the years ahead, broadside

(Concluded on page 146)

The Analytical to Hospital

by ROY HUDENBURG*

WITH RAPID ADVANCEMENTS in techniques of patient care, hospital administrators involved in new building programs can be properly concerned with preventing their new building from being obsolete before it admits its first patient.

Certainly, they will be asking for an out-of-date hospital if they permit traditional concepts of operation to be applied in the design of their new building. Their only hope of achieving functional originality is to make a clean break with preconceived notions and to apply logical thought processes to every step of the planning work.

Banks, conservative as they are, have departed from time-honored custom in their planning, but generally hospitals have been much slower to discard a reverence for such custom. To overcome this tremendous inertial drag, the progressive administrators have no option but to shake professional colleagues from ultraconservative attitudes that stand in the way of planning originality.

One hospital planning approach that tends to perpetuate the obsolete hospital is the "Let's sit down with our various department heads and find out what they

*Mr. Hudenburg, a hospital consultant, is director of clinic facilities, Community Health Association, Detroit, Mich.

Approach

Planning

want" technique. Quite naturally, they will ordinarily want a larger, improved version of what they have, because this is the environment in which they are accustomed to working.

Still another technique is the "Let's see how George did it" method. In this method the administrator, perhaps one or two board members and occasionally one of the leading physicians make a Grand Tour of relatively new hospitals in other parts of the country, with the aim of copying the best features of each. The word "copying" epitomizes the pitfall of this method, because it results in the duplication of planning that may be at least five years old and may have been "copied" from a building plan developed five years earlier.

The Grand Tour is not to be scoffed at, however, when properly used. It has great validity when used to see how George is developing new methods, possibly within older facilities that are probably not ideally suited to these methods. But the point is: it should be the methods—and not the facilities—that are studied.

If the new hospital is to meet its function and to have the necessary freshness of approach, the administrator must also prick up his ears and challenge with a repetitious "Why?" every statement that begins or implies "This is the way we usually do it."

If the administrator is determined to provide the necessary leadership that will result in a hospital equipped to meet contemporary challenge, he must first set his house in such order that he will be able to take the necessary time away from routine administrative duties. The job of sparkplugging a good building program is so arduous, demanding and time-consuming that the administrator who wants to do it right will find he needs a competent backstop to handle four-fifths of the administrative detail of day-to-day hospital operation. He must be represented by competent assistants and department heads to whom he can delegate many of his administrative duties—or he must be prepared to abdicate as leader of the planning program.

In outlining the approach to planning, this article intentionally will ignore all the factors having to do with decisions as to the need, optimum size and location of the new hospital structure, as well as the all-important problems of financing. Realistically, it must be obvious that a part of the available time the administrator must be assured of will be invested in the very vital problem of financing. It is also presumed that the need of construction has been manifest and that the necessary studies as to the size of building, the functions it will house and whether it will be an addition to an existing building or a new building, have been carried out on a sound basis.

To prepare for the architectural planning, the administrator will be wise to expend his initial efforts in the study of new developments with respect to the philosophies and methods of operation in various departments, disregarding architectural elements until much later. There must be a careful analysis of current operating problems in terms of how others are meeting them and how they may best be resolved in terms of local problems.

All of these functional problems, and perhaps revolutions, must be faced squarely in terms of whether the present staff can be sold on their values and cajoled or educated into adopting new methods. As a matter of fact, it may even be necessary to measure with a cold analytical eye the ability of department heads to meet the challenges of greater responsibilities and new tricks.

For instance, in the realm of nursing there is considerable lip service given to team nursing in some instances where actual adoption of its principles is rather slow. One new hospital building, opened about five years ago, was designed entirely around the concept of team nursing and the facilities were built to take advantage of its potentialities for better patient care. It was bitterly disappointing to see these facilities being utilized in a pattern completely divergent from the philosophy behind their planning by a director of nursing with a great deal of seniority who was psychologically unable to adapt to the principles of team nursing.

This discussion cannot go into the equities nor the emotional facets of departmental staffing, but it must point out that if modern facilities are to be provided, those who administer them on a supervisory level must have the flexibility and orientation that will enable them to adjust their methods to new situations.

All activities that must be housed in the new structure must receive the same scrutiny and critical analysis by a mind that has been conditioned to disregard the compulsive decision that "the way we are doing it now must be good because it has been successful for the last 20

Preventing Built-in Obsolescence in Planning of New Hospitals

DO NOT	"Find a good hospital comparable to what we want" and duplicate it.
DO NOT	waste valuable time touring the county to see the "best new hospitals."
DO NOT	hesitate to "be original."
DO NOT	take for granted the validity of other's opinions.
DO NOT	delegate planning leadership.
DO	make advance agreement with architect and consultant on their willingness to assist in research and to depart from custom.
DO	budget for additional consultants for various departmental areas.
DO	challenge and test every statement that begins "What we usually do is . . . . ."
DO	study journals for new trends in treatment, in distribution of care and in production methods.

years." This studied departure from the traditional must be particularly applied to the whole problem of hospital logistics. It must apply to the handling of supplies from the tailgate of the truck to the bedside.

It is vitally important in the production aspects of hospital operation, as for instance in the operation of the central sterile supply department. Now that the central sterile supply department is acknowledged as supplying the entire hospital with sterile materials, it may be found that there is no valid reasoning that relegates its administration to the surgical supervisor. The needs of the department of surgery, as well as obstetrics, nursing units, and outpatient departments, can secure adequate recognition, for instance, in the development of an active central sterile supply committee. Therefore, this department might better be independently organized with a registered nurse as its supervisor and staffed by production workers.

This same investigation of better methods should apply equally to patient care areas and areas generally dominated by medical staff. Generalities obviously are never fairly applied to one class: there are physicians who are adaptable and flexible in their requirements for working environment but, again, many tend to cling to what they have been working with. In some cases this attachment goes back to the kind of facility and organizational pattern to which they became accustomed in their internships and residencies. For this reason it may be equally necessary to research the surgical setup and the outpatient care methods preparatory to a program of selling the physicians and orienting them to a new type of facility.

To illustrate why this may be necessary, the example of the arrangement of doctors' office suites seems very appropriate. Internists generally, in the design of clinic facilities, seem to expect multiple examining rooms. They cling to an idea that their time is saved when patients can be prepared for examination in one room while they are working in another. As they become busier, many of them attempt to solve the problem by providing more examining rooms. The result is invariably increased waiting time for patients in both examining room and general waiting room.

Yet, the research and experimentation done by the Nuffield Provincial Hospital Trust* in England has proved conclusively that the physician's time is saved and the patient's time is markedly saved when the problem is solved by the use of a single examining room in which one patient is seen at one time on a strict appointment system. The experiment has been proved in experiences in several New York clinics where tight appointment schedules have been instituted and physicians have been reoriented to this one-at-a-time method of handling patients.

*Studies in the Function and Design of Hospitals. (Nuffield Provincial Hospital Trust and University of Bristol, 1955; Oxford University Press, London and New York.)

A Time to Review Procedures

The next step in the pre-architectural planning work program is an analysis of the hospital's administrative organization. It is obvious that a long look at methods may well raise questions as to the chain of command and who is going to administer what. If the building is to be larger and to give more services, it may become necessary to increase the supervisory staff and to decrease the span of some supervisory controls. The development of a new organizational chart, based on a new approach to operations, may well have a substantial effect on what functions should be grouped physically together and which ones may be separated because controls have changed.

To use a hackneyed example, obstetrical nursing may be responsible for formula preparation for the simple reason that the formula room currently adjoins the nursery. If on examination the preparation of infant formulas appears to be a function of dietary production, the new organizational pattern would reflect such a change and require an architectural decision to place the formula room near, but not in, the kitchen. A more unique decision might be that infant formula preparation is a matter of sterile techniques and therefore should come under the control of the central sterile production department. In any event, in the development of the new organizational pattern every function should be examined for its true relationship to other functions without too much worry of "how George does it" or how it's now being done.

With the chart of organization completed, the next job is to devise a staffing table calculated to take advantage of the estimated savings that can be accomplished as a result of the study of new methods and new distribution patterns. Preparation of this staffing pattern will present a new opportunity to weigh the decisions with respect to organization and arrive at a final, well-sifted plan of operation.

This staffing pattern should then be priced in terms of hospital personnel policies and predicted salary schedules. When this work is done carefully and a budget is prepared on the basis of such a staffing table, unpleasant surprises with respect to the operation costs of the new

building may be avoided well in advance of construction.

The foregoing steps involve administrative study and decision in which the services of a consultant providing an administrative survey may be helpful. However, the administrative survey should be used to assist to the administrator's eyes and legs, but not as a substitute for the administrator's brain. If the survey is to be meaningful for the particular hospital under study and is intended specifically as a guide for architectural planning, it must be developed under the direct leadership of the administrator and its recommendations must be subject to the administrator's persistent inquiry of "why?" and "on what authority?" For these purposes, the survey recommendations must stand up to searching challenges; and undocumented opinions must be examined to ascertain that they are founded in reasoned analysis or in tested experience.

The groundwork has now been laid for the architectural approach. After the established criteria for the selection of architects and consultants have been satisfied, this approach to planning requires investigation into the willingness of the candidates to accommodate themselves to administrative teamwork in investigation. The architect or consultant who has all the answers and is ready to relieve the administrator of all of the planning headaches is the wrong one for the job.

However, it should not be presumed that either the architect or the consultant should be expected as a matter of course to enter into a planning operation based on research and study until the required approach has been carefully spelled out to them. Most who are experienced in hospital work expect to spend a certain amount of time on research, but they should have the privilege of knowing what is in store for them before agreements are reached and fees are set.

The Plans Get "On the Boards"

The first job of the team will be to develop a written architectural program.* The architect's function in the development of this program is essentially that of a data processing machine, in that he will absorb the various data previously developed by the consultant and the administrator and resolve the desired results of the building program into a written architectural description. He will require information as to construction budget, required functions, required physical relationships between functions and conclusions reached with respect to the number of beds according to medical services. He will be helped considerably if the administrator's research into methods organization and staffing has been summarized in concise written form. However, any such written work will require augmentation by a series of conferences with the administrator, the consultant and, in some instances, key supervisors.

When this architectural program has been accepted, it will in essence set the architectural stage. As a budgetary guide it will frequently include information on the desired level of interior finishes. After program approval, the architect will be called upon to develop a tentative draft of building area allocations. This draft will attempt to set down, room by room, the required content of the new building with room sizes so that a total net area can be agreed upon. With the use of an appropriate formula, the architect can then transform this total net area into a gross area figure to which a unit cost can be applied, resulting in the first preliminary budget for construction.

This first attempt at designating area content has been referred to as a preliminary draft because in all likelihood the first attempt will have shown some areas to be smaller than the administrator may have in mind and others larger. It may show functions that have been omitted or functions that the administrator may think superfluous. In all likelihood, it will show a total area and probable budget in excess of the hospital pocketbook, so that at this stage, before final area allocations are decided on, the first attempt can be made at trimming to meet a budget.

Where Planning Affects Function

It may come as a surprise to some that so much energy and work could have been expended on planning before the architect has drawn a line. However, with the above studies and decisions, the groundwork has been laid for the architect's development of the schematic drawings. These are small scale drawings that are used by the architect to develop the over-all shape of the building and its internal arrangement. At this stage, the architect determines how broad and tall the components of his design will be.

Of much more concern to the administrator at this stage is the internal arrangement of blocks of functions or departments that the architect will be fitting into his design scheme. As the administrator is able to give guidance to the architect during the course of these schematic drawings on the basis of the organizational studies previously completed, advantageous or awkward lines of traffic flow and material handling will be established or avoided. From the standpoint of effective over-all operation of the hospital, this is the most important phase of all of the planning effort.

Later work in the development of internal department layouts is important but can be changed after the building is operating if mistakes have been made. However, there is no retreat from the broad decisions as to structural arrangement that are made in this schematic drawing phase.

Successive generations of administrators will be required to live within the framework irrevocably created when schematic drawings are finally approved. For these reasons the administrator, in working with the architect during the schematic phase of design, must be objective and uncompromising in undertaking to achieve with the architect the best possible interrelationship of activities and traffic flow. The architect and the consultant should be willing to spend all the time necessary to arrive at the best plan at this stage, since all of the ensuring work in planning will be facilitated if the schematic drawings are as perfect as the combined ingeunity of the planners can achieve.

One means of working toward this goal of perfection is to continue the challenging of opinions. For instance, if it appears sensible to put the surgical suite, the x-ray

*See: *Manual of Hospital Planning Procedures,* 1959, American Hospital Association; also *Handbook of Architectural Practice,* 1958; Book III Sections 1 & 2; American Institute of Architects.

suite and the emergency department in the basement, this could mean that in turn the kitchen might have to move to the second floor. The administrator should never accept the statement that "we never put kitchens on the second floor." The only way to find out whether or not such a plan is feasible is to look at it, study it, analyze it and try it. It is just possible that even though the bare idea might sound weird, its successful incorporation into the plans might bring about many advantages.

In testing the schematic drawings the following questions should be asked: Has travel been minimized? Are bedside requirements available to the nurse with minimal expenditure of her time? Does the plan locate each department in its highest possible priority location? Can each department be expanded in the future without undue cost? How can future functions be added?

The final test of the schematics comes when this phase of the work is ready for approval and when once more the architect estimates cost, and the planners compare the cost estimates with the budget. It may be necessary once more to make planning adjustments in order to avoid unpleasant surprises when the bids come in.

On the basis of the schematic drawings, the architect is ready to begin the preparation of the preliminary drawings, which will show every room, every counter and cabinet and every door. With this phase of the work, the architect should be expected to bring along the development of the mechanical system in order that when working drawings are prepared later on there will not be the sudden appearance of a ventilating or pipe shaft in a strategic location in a room previously ideally planned.

In this phase of the work the designing will be department by department, with each department being confined within the limits previously established in the schematic drawings. Department heads must understand that the schematic limits of their area are budgetary considerations that they must live within, just as they operate their departments with a dollar budget.

It is in this stage of the work that all of the methods improvement studies the administrator has made will begin to assume practical significance. Production areas will require attention in detail. Department heads must have an opportunity to participate in the development of facilities that will affect their work, but always with the administrator providing leadership and questioning the validity of opinions. At this stage, money is always wisely invested when used to employ specialists to consult on departmental layouts.

The specialists should be chosen for their basic knowledge of their specialty area and their fresh approach to departmental operations. In many instances it may be advisable to bring in more than one specialist to consult on these specific functions, so that the best ideas of all can be incorporated in the planning. If the planning is successful, as it should be, the investment in planning will be recaptured many times by decreased costs of operation, more productive workers and improved service to patients.

This discussion so far has dealt with efficiencies and economies and on the surface has not appeared to be concerned with patient care. This apparent indifference to the care of the patient, however, is only superficial, since experience indicates that when proper handling of materials has been achieved, the nursing staff will be re-

(Concluded on page 147)

Purchasing for Hospital

HOSPITAL PURCHASING COVERS a wide range of items. We buy everything from "soup to nuts," from "live guinea pigs to cadavers," from "chemicals to coal," from "tomato juice to tractors." Professor Terry's text on "Management" mentions the four M's: Material—Money—Machinery—Men.

For purposes of this discussion, material or machinery can be described as equipment. At least, it will be limited to equipment. Perhaps the most effective way to do this is to discuss the planning, organizing, directing, leadership and control used in the buying of the complete equipment for a large new hospital. In this area we have had some experience; and the equipping of such a building, from the ground up, represents a sizable project.

In order to completely equip a hospital, much preliminary leg work is necessary. First of all it is necessary to know what kind of a hospital it is, where it is to be located, what kind of patients it will serve, and whether or not it is a charity hospital. These and many other questions which occur to the administrator and the board will be asked and answered before plans are drawn. Once definitive drawings for the building are prepared they

Equipment

Construction

by **J. FRED KNIGHT**
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can be submitted to the various using departments for review. Copies of these should also be placed in the hands of the purchasing officer who is to buy the equipment. The drawings will undoubtedly outline the use of the various areas and the locale, or location of specific built-in items, access areas, elevators, etc. At this point it might be wise to suggest that the proper location of a large heavy-duty freight elevator, with ready access to endgate level loading platform, will materially reduce the problems of receiving and local delivery of all heavy equipment. A hoist or overhead beam will be necessary for some large pieces, such as sterilizers, x-ray transformers, etc.

If each department has scale drawings of its area and will cut out "paper dolls" to the same scale, labeling each item as to what it is, and into which area it goes, it will not be too difficult to get either requisitions or lists of furniture and equipment for the various areas. This in itself will reduce the amount of friction in dealing with departments that have ordered more equipment than can be fitted into their space. In this connection, there is an excellent handbook available on laboratory furniture. This book was authored by H. S. Colman of the Mellon Institute entitled *Laboratory Design* and is published by the Reinhold Publishing Corp. in New York.

Another excellent aid is The U. S. Department of Health's book entitled *Design and Construction of General Hospitals.* This was published by The F. W. Dodge Corporation in collaboration with *Modern Hospital* Magazine and contains extensive and detailed lists of hospital equipment for both small and medium hospitals, broken down by departments, even to the extent of indicating the required quantities.

In several areas we found that laboratory setups envisioned the purchase of equipment: (a) beyond budgetary limitations, (b) included many items that we consider "gold-plated", (c) included quantities of items beyond the number of personnel in the department and (d) included equipment of such size and quantity that it would not be comfortably stored within the area, let alone unpacked and used. Here the only solution is the ability to make liberal use of a blue pencil.

After the equipment lists have been submitted to purchasing they should be reviewed for several things. First of all, the items must fit into the space. Second, the number of desks, chairs, tables, sterilizers—or whatever items are required—should be in keeping with the number of people working in the area, allowing reasonable room for some expansion. Next, a careful evaluation of the necessary service facilities and service connections must be made. In a word, does this equipment require, for its use, any of the following items:

- hot water
- cold water
- distilled water
- waste line
- gas
- compressed air
- vacuum
- alternating current
- direct current
- special voltage, or heavy duty service lines exhaust, such as for fume hoods
- extra capacity ventilation, special air conditioning or cooling, or other special housing or protection.

All of these must be evaluated and shown on the building plans if the architects, engineers and contractors are to include them in the mechanical drawings and contracts so that the equipment functions properly when installed. The above requirements also apply to laboratory equipment—that is, laboratory case goods, sinks, fume hoods, island base benches, etc. Some items even require more specialized service than implied above. For instance, an electron microscope cannot be installed unless the floor load will take the heavy weight concentration in a limited area. This unit also requires special cooling and must be put on a vibration-free base as well as installed in an area where all light can be obliterated.

Recently we located X-ray equipment in an area which is equipped with lead shielding to protect the staff and patients. Unfortunately, the air conditioning equipment which cools the transformers for this large radiographic unit are not normally operated in cool weather. The result (when the summer weather ended and the air conditioning was shut down) was that the transformer room reached temperatures well over 100 deg. F. Such temperature is intolerable to the operation of the transformers. Opening the doors destroys the lead shielding. This problem has yet to be resolved.

Many other factors go into the choice of equipment. Perhaps some of the more important in addition to services, size, space and weight requirement may be listed under the following headings: 1. maintenance 2. life expectancy 3. cost of installation.

In many of the areas the department head, doctor, laboratory supervisor, chief nurse, hospital pharmacists or other key personnel will have very definite ideas as to exactly what is wanted, and will wish to make their purchases based on brand names. While it is desirable to pin down the specifications by looking at manufacturers' catalogs, specifications and data sheets, the danger arises in closing out competition and in the possibility that the buyer's hands may be tied and the best price obtainable, even for an exclusive item, will *NOT* be granted to the hospital.

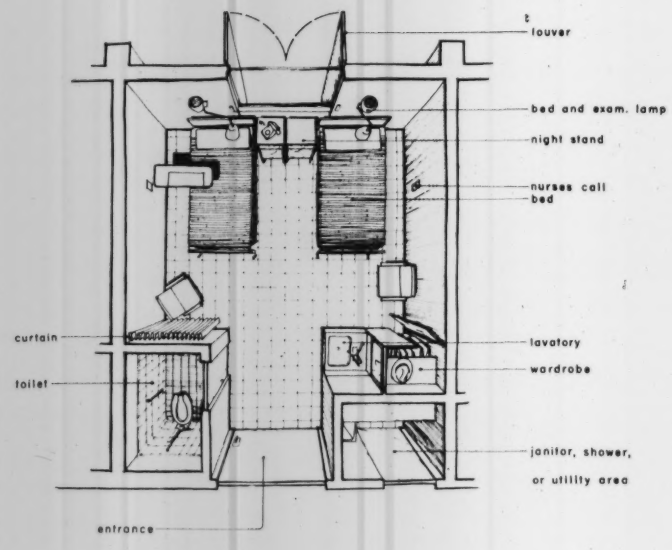
Therefore we, wisely or otherwise, have elected to endeavor to follow the bidding practice outlined in the state procedure even when we are not required to do so. The general specification, with certain limits included therein to guarantee capacity, size and quality of item, may help to pin down the requirement. In addition, the use of a manufacturer's name and catalog

(Continued on page 164)

THE NEW PROVIDENCE HOSPITAL, ANCHORAGE, ALASKA

1936: A Medical Outpost
1960: A Medical Center

by **JAMES S. MOORE, A.I.A. • Los Angeles, Calif.**



typical 2 bed patient room

A MEDICAL OUTPOST was established in 1936 by the Sisters of Charity of Providence in Anchorage, Alaska. The 50-bed facility included a maternity hospital with a nursing floor for chronic disease care. It was constructed on the outskirts of what was then a village. Many of the Sisters' friends thought they had built a facility that was too large and that they may have gone too far outside of Anchorage in the selection of a site.

After only 24 years the Sisters in Anchorage were faced with quite a different problem. The facility was no longer oversized, but had been crowded to a capacity of 75 beds within the initial 50-bed building, and more beds were needed. The institution was no longer on the outskirts of Anchorage as the city has surrounded it. Adequate expansion to provide medical facilities, parking, housing and other services became impossible—or highly impracticable—at the original site.

The solution seemed easy: find another site and build a new hospital. This, as anyone in the hospital field knows, involves a considerable amount of money—particularly in the new State of Alaska. Because of unusual transportation problems, a short construction season and a scarcity of skilled laborers and large general contractors, construction costs in Alaska are 70 per cent higher than on the west coast and 60 per cent higher than in the northern midwest. (The cost of living index alone is 140.8 per cent of Seattle prices). This meant that in order to provide the 175 beds needed immediately, a sum in the neighborhood of $6 million would be needed. This would be a staggering target in any area, but especially in one made up largely of transient or pioneering people, both of whom are limited in reserve capital. Since Alaska is expanding rapidly, all excess public capital must be used to finance business growth and to provide necessary public utilities. Local bond issues were considered, but the rapid growth of the sprawling community where sewage, water, streets and other public services are excessively expensive had already pushed the city to its practical bonding capacity.

Many larger hospital boards made up of successful businessmen in more established communities would have considered the task impossible. But the Sisters of Charity of Providence had learned many years ago not to look at any problem as insurmountable. A ray

of hope pointed toward the possibility of getting Hill-Burton funds as well as matching money from the State of Alaska. At this stage Charles Luckman Associates were selected by the Sisters to become part of the team to plan a new medical center which would serve the country's newest state. Despite long and varied experience in planning and designing medical facilities, the firm soon realized the Providence Hospital presented a unique challenge to provide a maximum number of beds and facilities for a limited budget in Alaska.

Even superficial study revealed that Anchorage did indeed require additional civilian medical care. The city has grown at the rate of 25 per cent each decade, with the bulk of residents having arrived since 1945; there are about 85,000 people within a 10-mile radius of Anchorage. Nearby oil explorations and the rise of the area in importance as a military and civilian air center points to a possible 1980 population variously estimated at from 112,000 to 275,000. A survey by the Alaska Department of Health and Welfare further underlined the need for hospital beds by designating Anchorage as the area in greatest need of additional beds.

Conferences with the Alaska Department of Health and the U. S. Public Health Service revealed that some money was available, but it was far less than the amount required to provide all the necessary facilities. The Provincial Council reviewed the financial situation in the light of other demands being made on them by expanding communities that they were serving in the western United States and found that they could provide only a portion of the balance of funds needed. It therefore became evident that some solution must be found so that 175 beds could be provided with the money available.

Anchorage is a progressive city, with a competent City Planning Department fully supported by civic officials. A master plan has been prepared for Anchorage which reserves a certain area of adjacent federal land for medical and educational purposes. Forty-five acres were available for a general hospital, which would form the nucleus of a medical center. The Sisters of Charity of Providence will provide a facility in this medical center which the city itself could not finance for some years to come.

A federal hospital for mental patients is being designed on property immediately adjacent to this site and will depend upon Providence Hospital for supplying surgical as well as other general hospital facilities.

During this period of study and planning, Sister Elizabeth Clare, the administrator, and Sister Benedict, the treasurer, were working with Mayor Lounsbury, businessmen and the community in an effort to obtain additional funds. Their efforts and prayers were rewarded. The faith of the townspeople had encouraged the Sisters to proceed with the hospital.

A Luckman Associates team, headed by M. C. Lewis, project architect, worked with the Sisters to develop a plan which will enable them to build 175 beds in a new facility. It can be easily and logically expanded into a 250 to 400-bed medical center as the need grows and funds become available. This, again, requires considerable imagination and involves many decisions by the team organized to develop this medical center.

An expandable hospital is a phrase heard often today—in many cases "expandable" means that the hospital can expand according to plans that are prepared at the time the initial design is conceived. This is not true expansion because experience has proved that it is impossible to predict over a period of three to five years what the needs of the hospital will be or to predict the advances in medical techniques and procedures which would require new or enlarged medical-surgical facilities.

Providence Hospital was designed in the belief that the only expandable hospital is one that allows expansion in one or more of several different ways. This truly expandable hospital must also be capable of making internal rearrangements to keep the original hospital a first-class medical facility. This philosophy has been followed at Providence with the incorporation of several unique planning ideas, some of which are as follows:

1) The surgical and adjunct facilities are pulled out from under the nursing tower structural system which was designed to fit patient rooms and their service facilities. The roof of the adjunct area is supported by a clear-span truss which creates an area with a minimum of columns and enables the area to expand in three directions. The structural system allows for any alterations without being handicapped by columns, bearing walls or shear walls. The space available between the ceiling and roof enables plumbing and mechanical changes to be made with minimum effort and expense.

2) Service facilities such as dietary, storage, shops and mechanical equipment, which have no direct connection with patients or the medical staff, have been located in an industrial-type building adjacent to the hospital and connected on a lower service level by an underground tunnel. In addition to the reduced cost of this type of building, another advantage was gained in the easy expandability in almost any direction. Further advantage is that the

(Concluded on page 150)

CHECKING PLANS for Providence Hospital, Anchorage, are (l. to r.) James S. Moore, vice-president, Chas. Luckman Associates, Los Angeles, Calif.; Sr. M. Loretta, F.C.S.P., provincial treasurer; Architect Charles Luckman, and Provincial Superior Rev. Mother Judith.

for the Aged

THE NEW SAINT ANNE'S HOME

by RT. REV. MSGR. ARTHUR E. RATIGAN
PAUL DUFFY, M.D.
ROBERT HALL, A.I.A.
Rochester, N. Y.

THE CARE OF THE AGING and the chronically ill is a problem which has been increasing rapidly in recent years. To determine precisely the needs of these citizens, many communities have initiated surveys of the aged and the chronically ill population and the facilities for caring for them within their communities. Monroe County, in which Rochester, New York, is situated, has completed its chronic illness study. In addition to a great fund of statistical data on the problem, it also makes certain recommendations for the solution of the problems, one of which is "that the homes for the aged be encouraged to accept responsibility for providing services to persons who require not only a home but who on application require medical and nursing care short of hospital care." Census indications are that in the future a far greater percentage of a greatly expanded population will require this type of care.

St. Ann's has noticed this trend, too. As time goes on the average admission age and the average age of the guests in the home get higher and higher. This results from the ability of elderly people to maintain themselves independently for a longer period of time; but, unfortunately, it also means that the need for more advanced nursing and medical care becomes increasingly apparent. The staff must direct its care not only to the needs of these people as they exist, but to improvement of their physical condition, to their rehabilitation where necessary so that they may achieve some level of self care and enjoy the personal dignity of independence within the Home as long as possible.

It may also be possible to offer these same medical and rehabilitative techniques to the aging population of the community who are not as yet guests at the Home, thus delaying the time when they will have to be admitted as inpatients. To this end, St. Ann's is planning to offer the facilities of the Home to the aging on a day-care basis.

St. Ann's will be a large institution, as homes for the aged go. It will have a capacity of 354 guests, tentatively classified as 216 nursing care patients, including eight priests and 138 so-called well aged guests. In addition to this, a convent is planned for 30 Sisters of St. Joseph who will staff the home.

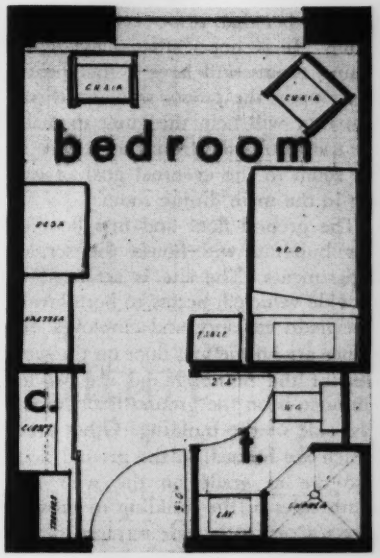
While it is true that all people in the well aged group will not become

chronically ill before their death, it is equally true that one cannot predict how many will, or what level of care they will require. Current available statistics indicate, however, a much greater demand for chronically ill beds than well aged beds. Therefore, St. Ann's will be an institution that can readily be converted totally to the care of the chronically ill. The guest rooms are all convertible to nursing rooms; the rooms are arranged into double nursing units, and all the standard facilities for care of the chronically ill will be available for use on all floors.

At the same time it must be kept in mind that long-term care of the aged means that to the guest the institution will be his home in a very real sense for a long time. Therefore, the home should be so designed that the specialized services which are offered to the guest are added to his normal way of life and are not a way of life in themselves. The specialized services must be integrated into a normal, home-like atmosphere and should be offered in a manner which respects the privacy and individuality of the guest.

In recognition of this principle, almost all of our guest rooms are private rooms. They will not only provide the privacy to which the aged are entitled, but also will go a long way toward eliminating some of the institutional feeling characteristic of most similar homes in the past. Along with this concept is the privacy afforded by the private toilet rooms provided in each room. These toilet rooms have been designed especially for the use of wheel chair guests. The folding door can be opened from either end and is so located that it will pass in the few inches between the wheel chair and the guest's feet when he is using the watercloset, leaving the wheel chair outside the toilet room. Bathing facilities for private rooms are in two common bathrooms because the aged require attendant bathing. Two areas are provided to permit mixed occupancy on each floor and to eliminate the necessity of robed traffic in the elevator area. There are two rooms on each resident floor which will accommodate two guests each. These are for the use of couples, or sisters, or brothers, or friends, who wish to live together. They are placed near the main nursing station so that they can be used for intensive nursing wards if the necessity for this service should develop.

There are 46 beds on each residential floor and they have been developed into a double nursing unit. There is one central nursing unit containing the nurses' station, medication area, nurses' lounge and service core, serving two nursing units each of which has its own utility room and bathing area. During the day, each nursing unit will be operated by its own staff out of its own utility room and under the control of the charge nurse at the central nursing station. At night, this arrangement will allow for a reduced staff working out of the main nursing station to care for both nursing units. The orientation of both nursing units is northeast and southwest to allow for some sunlight into all bedrooms and also to eliminate the necessity for the guests to look at any other part of the institution when they are sitting in their rooms. Again, planning these

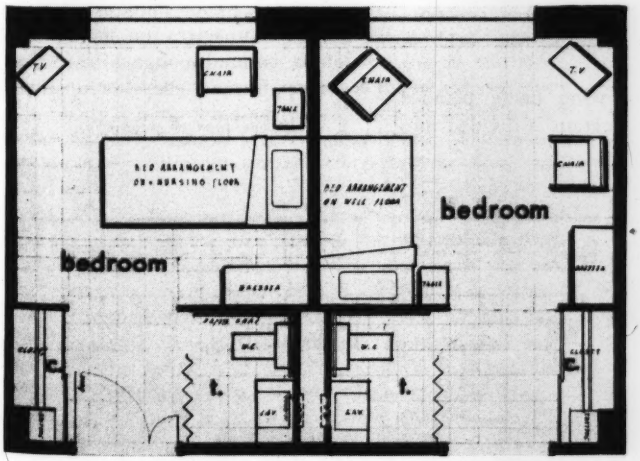


Typical Sister's Room

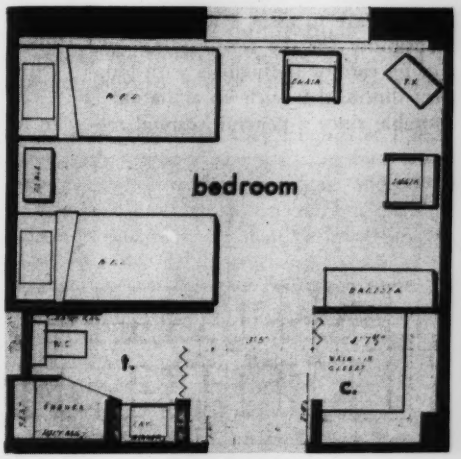
floors to eliminate long cross walls exposed to the view of the guests reduces the institutional feeling of the home and enhances the feeling of individuality in the guest.

Each residential floor will also have three small lounges and three sun decks, rather than large solaria. The aged individual can relate himself more easily to small groups of people such as he is accustomed to in his own home rather than large groups such as might use a solarium.

There is also a small dining room on each floor for the use of those guests who for one reason or another could not or should not use the main dining room. It is the intent that these small dining rooms provide the opportunity for unusual cases to have their meals together in a social atmos-



Typical Single Guest Room



Double Guest Room

phere rather than to be served in their rooms. It is hoped that these small dining rooms will have a therapeutic effect upon the guests who use them; that they will help the guest to make the transformation from tray service in his room to the eventual goal of eating in the main dining room.

The ground floor and first floor of this building will house the service departments. The site is arranged to provide vehicular access to both levels. The main entrance and employes' entrance are on the first floor on the west side of the building and the service entrance is on the ground floor on the east side of the building. Other areas which are housed on the ground floor also are at grade on the west and south sides of the building to provide direct access to outside terraces, picnic areas, etc.

The first floor contains, in addition to the main waiting room and elevator lobby with the usual information desk and communication center, a large administration area designed for the comfort and convenience of the guest as well as the staff, a medical section, snack bar and the chapel. The medical section has been developed to house an extensive medical care program to achieve the objective of "medical and nursing care short of hospital care" as recommended by the Monroe County Chronic Illness Study.

In order to assist the homes in this objective, the study made another recommendation that "non-profit homes for the aged which serve long-term patients seek affiliation with an interested general hospital. The terms of such an affiliation should include the sharing of medical, rehabilitation, laboratory and other services and facilities." It is apparent, if homes for the aged are to assume additional responsibility for the medical care and nursing care of individuals with long-term illness, that such an affiliation is desirable since a general hospital represents a pool of highly developed consultative services.

With such a team of specialists to assist him, as well as physical facilities for specialized diagnostic work, the medical director of the home can enter upon a medical program for the guests which will truly represent total medical care of the guest. With the home-hospital team working together in a positive approach to the problems, it is expected that the results will end once and for all the negativistic attitude prevalent in the past that the course of degenerative disease is unalterable.

To this end, a continuing medical program is being developed, beginning with the complete pre-admission physical examination of the guest which will be given in the medical department of the home by the medical director and his staff, using the equipment in the home to assure uniformity. The chest x-ray and EKG as well as routine laboratory determinations will be done in the home, with special determinations done in the general hospital, if indicated. The results of this examination will be received by a staff of specialists from the home and the hospital, including the medical director, director of nursing, physiatrics, psychiatrist, opthamologist and other specialists as indicated. This team will then map out a medical program for the guest, to be carried out within the home. A periodic re-evaluation of each guest will be carried out by this staff as frequently as the case requires. Every guest will receive a re-evaluation at least once a year. Through the maintenance of accurate, up-to-date medical records within the home, it is expected that a substantial contribution can be made to the field of gerontology.

The medical wing being planned to house this program is divided into three sections: medical, physical medicine and medical services, all under the supervision of a medical director. The medical section contains two consultation rooms, two treatment rooms, X-ray, dental suite, psychiatrist's office and attendant reception and record areas. The physical medicine section contains two hydrotherapy booths plus a Hubbard tank room, three thermotherapy booths and a full physical therapy gymnasium for the treatment and training of the physically handicapped plus the usual offices, reception, locker room and utility areas. The medical service section contains a laboratory, pharmacy, medical library and central sterile supply.

The main chapel is also on the first floor, and is slightly removed from the main lobby of the building to retain a sense of "going out to church." It is attached to the building by a corridor lined with quiet activities such as a multi-purpose room designed to serve as a meeting room for house committees, study clubs and the music appreciation programs, as well as the main library and the chaplain's office. The chapel itself is specifically designed for the use of the aged and all the pews are designed for the use of only two, three or four people to facilitate getting in and out of them. There is also an area especially designed for the use of wheel chair guests. It will accommodate a total of about 375 guests and staff at one time. In plan, the chapel wing will be located on the front of the building, and when viewed from the main thoroughfare or the driveway approach, it will appear as a free standing church, with the 10-story institution as a background.

The ground floor contains the main dining room, recreation room, staff cafeteria, cocktail lounge, kitchen, barber shop, beauty shop, occupational

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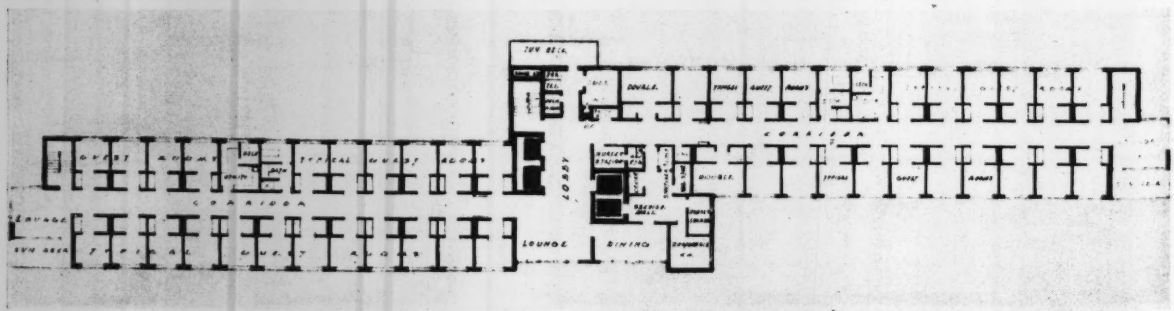


Typical Floor Plan - - Floors three through nine

construction

The Hospital of the *future*?

by CHARLES E. BERRY, LL.B., M.H.A.

WRITING THIS ARTICLE for an issue devoted to construction and building presents certain problems.* First of all my knowledge of building, like my knowledge of music, is slightly less than that expected of an expert. That is, I either like or dislike a song or building but I'm never quite sure why. Yet I must be expert because I'm writing a column on construction. Although I'm probably 50 years ahead of my time, here is my idea for the hospital of tomorrow.

All hospitals should be built in the form of a silo. (For city folk a silo is a cylindrical structure, several stories high, used to store feed for cattle.) Patients would be admitted at the lower level and immediately be rushed to the top floor. Here patients requiring surgery would be separated. All other patients would be assigned a bed which would be located in a large box something like a freight car. In this room everything necessary for a post-operative patient, care of mother and baby, etc., would be available. This completely individual unit 16 x 12-foot would be mounted on small rubber wheels. Once the patient was put to bed the movable unit would be hitched on to an endless chain, moving at the rate of one mile per hour. The chain would follow the corridor —in reality a ramp winding from the top of the cylinder to the discharge station several floors below. The speed would be so regulated as to take seven days to travel the entire building.

Think of the advantages! Every patient would have a private room. There would never be overcrowding; if you were busy, you could slow up the chain and put on more portable rooms. The doctors, nurses, technicians, dietitians, etc., could stand in one place and see the patients as they rolled by. For example, at meal time the food could be served from a point near the kitchen and the chain speeded up so that as each portable room rolled by an aide could step inside with a tray every 4½ seconds (all times estimated). This would eliminate food costs, hauling solid dishes, personnel, etc. The possibilities are unlimited, in fact, frightening.

Another advantage might be listed. The nurse with a master schedule in front of her could fill several syringes with antibiotics. After some training to improve her sense of direction, she could stand in one spot and issue medication as the patients rolled by. Over 1,347½ nursing steps would be saved twice daily (the accuracy of our figures may be questionable).

Just imagine a building without windows, little or no maintenance and less than one employe per patient. Patients would all receive intensive sporadic care within their own compartment. There would be need for one elevator only, coffee breaks could be eliminated, assistant administrators would become dispatchers and everyone would be so pleased with the service that funds would be donated to the hospital spontaneously.

Of course, like all really original ideas, there are some kinks that would require further study, but they are, my son assures me, relatively minor and could be solved with a minimum amount of effort by the experts in the field.

Before you smile, remember they laughed at Fulton, yet we have jets sailing around the world in four hours. (As previously mentioned our computations and source material have not been thoroughly checked, but once the computer is back in operation we shall be better able to project the idea in terms of figures.)

Naturally, every original thinker expects to encounter opposition and is prepared to sacrifice his prestige and sanity but, secure in the conviction that he is right, he will remain loyal to his ideas and ideals. If you feel that you have some constructive criticisms to offer please do not hesitate to write; if you have nothing constructive to offer, please don't annoy us, we have two hours of homework each evening. ★

*In the opinion of some, these would seem to have been insoluble.

construction

PLANNING food facilities for Hospitals

by RICHARD R. IUEN, A.I.A.*

HOSPITAL CARE is no longer only for the very rich or very poor. People in all walks of life and of all ages, with all kinds of diseases and sickness make use of hospitals. Widespread membership in hospital insurance groups makes hospitalization economically feasible for many families. Hospital insurance assures payments of bills, but it also limits the amount of money which hospitals receive for care and treatment.

Bed capacity, however, is greater than ever before; hospitals are literally bursting at their seams and are continuing to grow. Along with this growth, cost of construction, maintenance and operation are increasing at a very rapid rate. In step with this tremendous expansion of hospital service, the feeding of patients and personnel has become a big enterprise and, in many cases, requires from 30 to 40 percent of the total budget.

A recent hospital survey showed that *patients thought food and nursing care were as important as medical and surgical care.* An attractive tray can encourage the patient to eat and play an important role in recovery; therefore, the service of food to the patient may be considered the keynote of the whole food service operation.

For these and many other reasons, highly trained personnel are employed to operate and manage kitchens and to plan menus and diets. At the same time, funds are always limited so food facilities planning must be carried out with economy in mind.

To meet the goal of economical food service planning, the adminstrator, the director of dietetics, the architect and a qualified food facilities consultant must plan together. It is essential that each person keep an open mind and understand the problems and the points of view of all members of the group.

The primary objectives in hospital planning are: *first,* the comfort and satisfaction of the needs of the patients; *second,* efficient operation; *third,* safety, and *fourth,* economy in maintenance. The hospital dietary department must be designed with these four primary objectives in mind.

The essence of modern architectural planning is simplicity based upon function. The planning of food facilities follows the same theory and must be based upon saving steps, with production arranged in straight lines to increase efficiency, to avoid cross-traffic and to create pleasant working conditions. Size, as well as routing, is an important factor in efficient operation. Too much space causes extra steps; too little, inconvenience and confusion.

To assist architects, administrators and dietitians and to save time, effort and, above all, money, in the design and operation of an efficient hospital food facilities operation, we have charted recommended areas for various departments suitable for hospitals ranging in size from 100 bed to 900 bed capacity. These areas are based upon experience and tabulated records by the writer and research conducted by Ernest N. May, president of Charitable Research Foundation Inc., which has been a vital contribution to better food facilities for hospitals.

One might expect that the size of the various departments of a kitchen will increase in direct proportion to the volume of food prepared. This is not true, since the same basic operations must be performed in all kitchens.

The tabulated areas are to be used as a guide to determine space requirements in the preliminary stages of planning. It is understandable that the final shape of areas is largely determined by the size and layout of the equipment; therefore, the preliminary plans should be kept flexible until the detailed planning, which is the second step of design.

The flow chart is the first step in

*Architect and Food Facilities Consultant, Cincinnati, Ohio.

planning. It must show the steps in which the work must proceed, their sequence and the relationship of the various working units to each other. This chart must show procedure from the receiving area to storage, to pre-preparation, to preparation, to service, to consumption and to waste disposal. Also, for efficient operation, areas must be provided for offices, employes' toilet and locker rooms, janitor's closets, etc.

The *basic sequence of the food preparation* applies to all kitchens, large or small. Difference in the application of the plan usually depends upon three factors: *first,* the nature and complexity of the menu determines the amount and kind of equipment required; *second,* the number of meals to be served determines the size of the equipment, and *third,* the type of hospital or institution determines the food facilities being planned. For example, there is a great difference between the requirements of a private hospital and a mental institution.

Hospitals must provide food service for both patients and personnel. The plan must provide individual tray service for patients in areas remote from the point of food preparation and food service must be provided for personnel in the form of a cafeteria or table service.

Problems arise in keeping hot food hot and cold food cold. The aim of any plan of service is to have the patients and the personnel receive the food when it is best in quality, most palatable and in as short a time as possible after preparation.

There are *two basic plans for food service in hospitals;* namely, the decentralized and the centralized plans. For both plans, the food is prepared in a central kitchen. For *decentralized service,* the prepared food is delivered in bulk containers to the serving pantries in the patient areas where it is served onto the individual trays preparatory to distribution to the patients. In the case of the *centralized service,* the food is served onto the trays in the main kitchen area and then transported directly to the patient's areas by tray trucks, sub-veyors or dumbwaiters.

Each plan has its advantages and its disadvantages, and in choosing between the two systems there are many factors to be considered such as size of hospital and its physical form and function; whether it is a multi-story structure with short wings, a low building with long wings, or an institution with separate buildings; noise factor in the patient's areas; space requirements, etc. It is advisable to secure the services of a food facilities consultant early in the development stage, a consultant who is not directly connected with a manufacturer or an equipment dealer, one who is able to give unbiased opinions as to the merits of the two systems and of the equipment required.

It is essential in the development of the preliminary plans to consider the orientation of the food facilities to the hospital building as a whole. The location of the kitchen and dietary de-

Recommended Areas (not including main corridors) Hospital Food Facilities (100-450 Beds)

NUMBER OF BED HOSPITAL	100 TO 150		150 TO 250		250 TO 350		350 TO 450	
	Sq. Ft./ Bed	Sq. Ft./ Person	Sq. Ft./ Bed	Sq. Ft./ Person	Sq. Ft./ Bed	Sq. Ft./ Person	Sq. Ft./ Bed	Sq. Ft./ Person
Receiving	Min. .8	Min. .27	.7	.233	.68	.227	.66	.22
Receiving Office	Min. .4	.13	.35	.116	.3	.1	.28	.093
*Dry Storage (Reserve and Daily)	2.4	.8	2.4	.8	2.4	.8	2.4	.8
**Refrigeration—Walk-in								
Meats	.55	.183	.55	.183	.55	.183	.55	.183
Fruits and Vegetables	.6	.2	.6	.2	.6	.2	.6	.2
Dairy	.35	.116	.35	.116	.35	.116	.35	.116
Deep Freeze (Divide into 2 areas)	.55	.183	.55	.183	.55	.183	.55	.183
Refrigeration Total	2.05	.682	2.05	.682	2.05	.682	2.05	.682
Main Kitchen								
Cooks' Unit	2.1	.7	2.0	.66	2.0	.66	1.9	.63
Meat Preparation	.4	.133	.4	.133	.4	.133	.4	.133
Vegetable Preparation	.42	.14	.4	.133	.35	.116	.3	.1
Salad Preparation	.42	.14	.5	.17	.52	.173	.54	.18
Pot and Pan (Hand)	.4	.133	.4	.133	.36	.12	.34	.113
Pot and Pan (Machine)			.6	.2	.6	.2	.55	.183
Pastry	.86	.28	.8	.27	.8	.27	.8	.27
Janitors' Closet	.12	.04	.12	.04	.1	.033	.08	.027
Minimum Total Area	4.72	1.57	4.62	1.54	4.53	1.51	4.36	1.453
Dishwashing—Centralized	2.2	.73	2.2	.73	2.2	.73	2.2	.73
Office Diet, Supervisors	2.0	.666	1.5	.5	1.5	.5	1.2	.4
Utensil Storage	.12	.04	.12	.04	.15	.05	.15	.05
Storage (Paper Goods, Linen)	.4	.133	.4	.133	.4	.133	.4	.133
Trash Room—Garbage Disposal and Can Washing	.65	.2	.65	.2	.65	.2	.65	.2
Tray Service—Centralized	2.2	.73	2.2	.73	2.2	.73	2.2	.73
Truck Storage—Centralized	1.8	.6	1.8	.6	1.8	.6	1.8	.6

Person = total patient-employe load based upon ratio of 2 employes/bed.
*If divided use 4:1 ratio (3 weeks supply of cereals, sugar, etc.) (6-8 weeks supply of some canned goods) (52 weeks supply of seasonal canned goods).
**Based upon 4-day supply including daily refrigeration.

partment should never be in a basement or a dark, obscure location. Adequate daylight and plenty of windows are essential. While artificial lighting, ventilation and sound control have been invaluable contributions to contemporary planning, nevertheless, these can never replace the emotional benefits of an outdoor view or the cheerfulness of sunshine.

Beyond the fundamental divisions of the areas, such as receiving, dry storage, cold storage, dishwashing room, dining areas, etc., every partition and building wall should be carefully considered as there is little justification for ceiling height partitions separating the various working units within the preparation area. Partitions lessen the efficiency of supervision and increase maintenance costs.

The equivalent of daylight or from 75 to 100 foot candles of illumination should be provided for all working areas. The light from the fixtures, and that reflected by the ceiling and wall surfaces, should be of the proper intensity without glare.

Where do Odors Go?

Probably the greatest fault in most food preparation departments is the *lack of proper ventilation and control of temperature and of odors.* In mild climates, where adequate outside windows have been provided, proper sized exhaust fans over the heated equipment may suffice. However, in most areas, partial or complete air conditioning is advisable. To provide sufficient exhaust over the cooking equipment, the recommended face velocity for exhaust canopies should be 75-100 C.F.M., depending upon the type and shape of the canopy used. Also, there should be provided from 25 to 30 air changes per hour in the main kitchen and in the dishwashing area. It is important that the discharge from the exhaust system be extended well above the buildings or on the leeward side of the prevailing winds to carry away the cooking odors. Nothing is more nauseating to a sick patient than the combination of cooking odors.

A fully functioning kitchen and its related departments are noisy at their best. The *ceilings* and, where possible, parts of walls should be constructed to absorb the noise and yet be of such a nature that the surfaces can be easily cleaned. Reduction of noise is an important factor in achieving personnel efficiency and emotional comfort.

Since *floors* without question require the greatest amount of maintenance, types of flooring material to be used should be given careful consideration. The most satisfactory material is one which is non-absorbent, smooth surfaced, grease resistant, slip proof and hard and durable enough to withstand heavy traffic and trucking. The materials satisfactory in most cases are listed in the following order; first, marble with a honed finish; second, terrazzo treated with a hardener; third, vinyl tile where trucking or traffic is light; fourth, ceramic or quarry tile and fifth, concrete.

Build for Sanitation

The most satisfactory way to clean kitchen floors is with a scrubbing machine, flushing the floor with clean water and drying it with rubber squeegies. Floor drains should be well distributed throughout the kitchen and preparation area. It is easy to understand why it is essential that the floor should be smooth, and that all equipment such as ranges, ovens, refrigerators and steamers should be mounted on solid masonry bases with coved corners. It is also well to keep in mind that insects and vermin hide and breed in concealed corners, crevices and hollow bases; therefore, all areas containing food facilities should be designed for maximum sanitation.

While the dietitian is not a sanitarian, she has the daily task of seeing that the dietetic department is maintained properly and kept clean and sanitary. She must know what to expect from both equipment and building materials in exposure to cleaning operations. When considering sanitary features, eliminate all unnecessary legs, pipes or other impediments coming through the floors; allow space under and around all fixtures for a mop or broom. Place as much of the equipment as is practicable on casters to help facilitate cleaning. No amount of stainless steel will offset the obvious lack of total planning for cleanliness and durability.

Plumbing should be adequate, with well placed floor drains located in order that all areas are properly served, yet never so placed that any worker will be forced to stand on uneven surfaces. Hand lavatories should be conveniently available to all food service departments, each lavatory having foot pedal control with a spray nozzle.

All doorways and refrigerator doors must be not less than three feet wide to allow easy passage of trucks or carts. Raised sills or saddles between door openings should be omitted.

An adequate intercommunication system should be provided, connecting the dietitian's office with the receiving area, with all dietary departments and with the dietary supervisor's or nurses' station on each of the patient's floors.

In general, the following areas should be enclosed. The *Receiving Area,* which must be shut off to avoid drafts in cold weather; *Storage Space* for dry stores and staple supplies; *Potwashing, Dishwashing* and *Truckwashing; Offices; Employes' locker* and *toilet rooms; Garbage* and *Trash Rooms,* which should be refrigerated, or well ventilated and screened. This last area should be close to the exit from which trash is to be removed. Garbage disposal equipment has proven very satisfactory and is the most efficient method of waste disposal.

The general plan of food facilities should be compact, with a minimum of exits, all well controlled or supervised and locked at night.

Kitchen a "Stepchild?"

Architects are well schooled and trained in the fundamentals of planning. They are able to unscramble a complex building program and produce a simple, functional, well-organized, over-all plan. It is essential that the same logical planning and study be extended to the food facilities within the building. Too often the architect treats the planning of the food facilities lightly. Too often, because of the limits of his own field of vision, the architect will risk the proper functioning of the food service of a project and his reputation by calling in an equipment salesman or a manufacturer's representative — whose training is almost never equal to that of the architect—to plan the food facilities and to select and specify the equipment required. The food facilities for any hospital, institution or other project are just as important as the heating, ventilating, plumbing or electrical systems and should be treated in the same manner.

The hospital administrator and the director of dietetics should insist that the architect secure the best advice available for this portion of the work. It is well to remember that, after the

(Concluded on page 142)

construction

A New Approach to Intensive Care

by DAVID De BACKER, Associate Administrator • St. Joseph Hospital • Fort Worth, Texas

MANY HOSPITALS HAVE FELT the need to segregate seriously ill patients in special units more conducive to the strict treatment required. The solutions reached are as individual as the hospital solving the problem. St. Joseph's Hospital worked over a period of three years developing a plan that would meet all conditions of intensive care. This report will describe the transformation in design and principle and what the unit went through because of this long-term planning.

The original plan was simply to enlarge the existing surgical recovery. A general building program afforded an opportunity to expand and revamp this area to meet an anticipated increase in post-surgical recovery patients. In the initial discussion, the principles governing the operation of recovery were reviewed. When first opened, some 10 years ago, the room was for post-anesthesia reaction. Several conditions of the hospital had made a change in this. First, this hospital has a large emergency service and hence many patients with serious trauma. At the insistence of the doctors these severely injured patients were being admitted to the recovery room for pre-operative care, as well as post-operative care.

Post-operatively, the doctors asked that these patients stay longer than just the period of reaction to insure that they received intensive nursing during the critical recovery period. As this latter trend became more popular, other doctors were asking for the same post-operative intensive treatment for their more serious elective major surgery patients.

These conditions indicated that a new recovery room would have to be more than a place to handle post-anesthesia reaction; be designed to accommodate more patients resulting from an enlarged surgical suite (a part of the building program), and adequate in size and design to handle some patients for longer periods of time. With these considerations in mind, an area was selected.

Basically the same designing principle was employed as was used in the first suite, large open wards with beds readily accessible to the nurses, all patients easily observed and work stations centrally located. Piped-in suction and oxygen were specified. High bids on the over-all construction necessitated deferring the building of this new unit and for some time these recovery plans lay idle. In the meantime the principle of this "enlarged" post-anesthetic recovery got closer scrutiny.

Though concentration had been on the care of traumatic and elective surgical cases it was recognized that critical medical patients also presented problems for the nurse on the division. Special duty nurses, already in short supply, were inadequately prepared to work special treatment equipment which was becoming increasingly more popular. The assignment of seriously ill patients to discreet areas in a large plant and the growing popularity of the special equipment meant great outlays of money for duplicate equipment and its inefficient and improper utilization. Floor nurses, familiar with these patients care changes, were being asked to handle a good portion of the care of the critical even in the presence of private duty nursing. This meant time away from less seriously ill patients who needed and deserved professional care. Something more than an enlarged surgical recovery was needed.

The first approach to the solution involved three separate units. The existing surgical recovery would be remodeled for post-anesthesia care only. The new unit for pre-operative and post-operative care of trauma and post-anesthesia care of major surgery would be built. In addition, a new unit would be opened in another part of the hospital for the care of medical patients. Research showed that other hospitals had done this.

Two things became evident almost immediately. First, the estimated cost for construction and equipment was almost astronomical. Second, even if the construction were possible, surveys showed it would be nearly impossible to obtain enough qualified help to operate three special care units. Therefore, only one unit could be built to handle all three functions.

All previous drawings were thrown out and several questions were raised. How big a unit would be needed to handle post-anesthesia patients and those patients needing intensive care, both surgical and medical? What problems are presented from a physical layout standpoint in the joint care of these three different types of service? What problems could be anticipated in professional skills in giving intensive care to these three types?

None of the literature offered any answers to these problems. It had to be resolved from personal experiences of nurses and opinions and conclusions

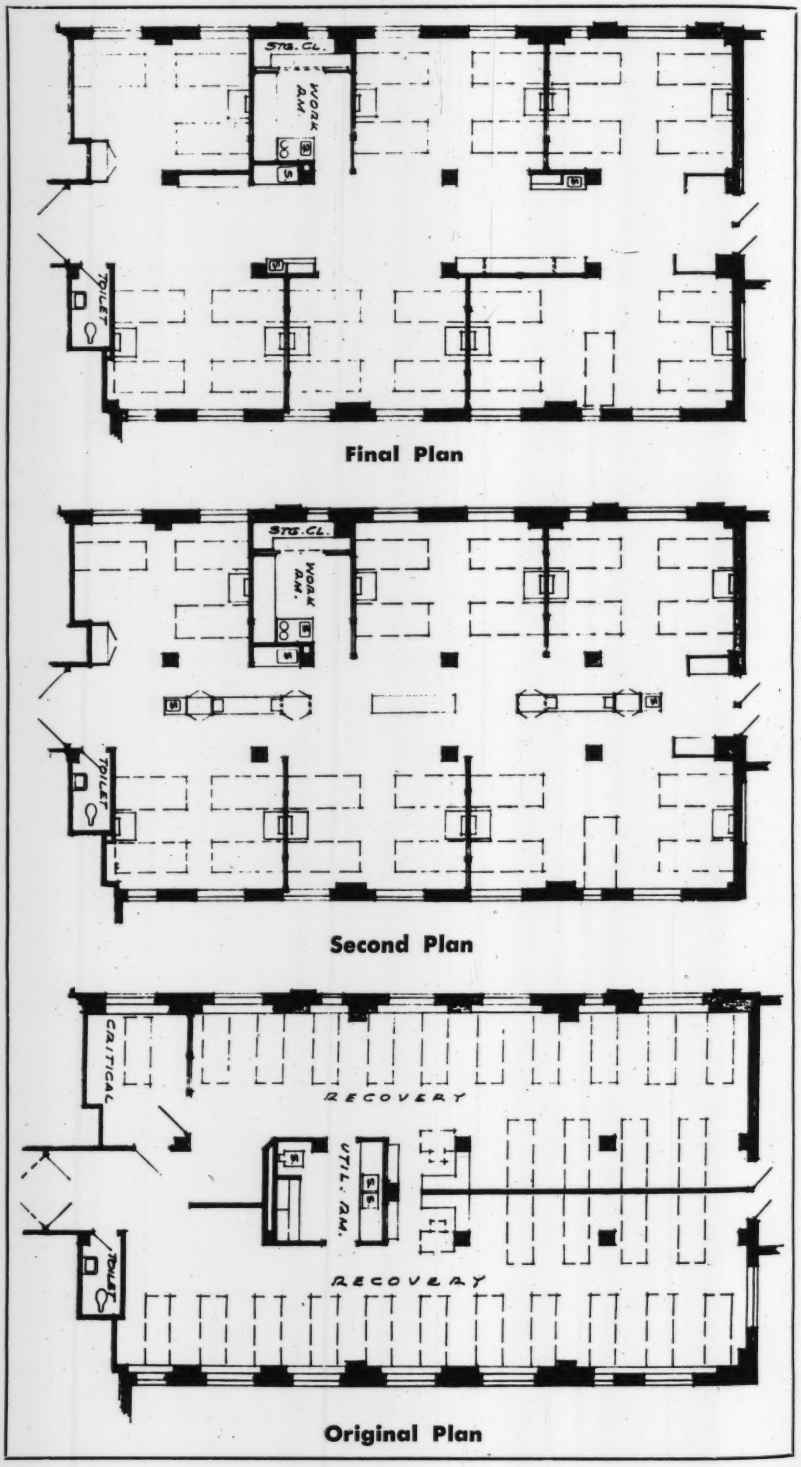
of the medical staff. The capacity of the unit was easy to determine—as many beds as the area would allow. Analyses were made of the census figures over a selected period of time. Recovery room admissions were studied to determine the type of patient admitted and the length of stay for each type. The number of critical patients, pre-operative and post-operative surgical and medical, cared for on the general divisions were studied with the considerations that they were possible candidates for intensive care. These analyses indicated that our 350-bed hospital needed a 20 to 25-bed unit. The first sketch would provide for a 22-bed unit, but there were other physical factors to consider.

Good observation was imperative so that, as nearly as possible, all patients could be surveyed: Accessibility to the patient is important, allowing the nurse to move freely from bed to bed with minimum obstruction. These points were covered in the original design.

Two factors of the physical layout posed problems. First, mixing unconscious patients with relatively alert patients presented problems in design. Second, the post-surgical and the seriously injured patient areas are often extremely noisy. Some medical patients, such as cardiacs, demand rest and quiet. These situations demanded elements of privacy not offered in the large wards and screens and drawn curtains were not sufficient in themselves. In addition, mixing surgical recovery patients with long-stay patients necessitates a certain amount of segregation for ease of handling. The dilemma was an apparent need for large open wards—with nothing but private rooms! What was designed was a radical departure from similarly named units.

Within the area previously allocated, six ward-like cubicles were fashioned to contain no more than five and no less than three beds each with the average (four cubicles) having four beds each. These cubicles were open-ended to the corridor. Adequate space was allowed for easy working around the bed and services such as oxygen and suction. In addition, further privacy was provided by dividing curtains. Windows 40 inches from the floor, two feet high, running the length of the cubicle wall adjoining two units permitted observation of all beds. Several guiding points were followed to arrive at exactly this design. Relative privacy was important. The separate units permitted noisy patients to be placed in an area quite distant from those needing quiet. Another point was that of staffing. It was felt that staffing should be done around one nurse per four patients. Thus one cubicle became one nurse's work area.

Charting and medication preparation areas also were fitted to this staffing principle. Two separate chart desks and medicine preparation areas were provided along the main corridor. These were located as islands in the



center of the corridor. Each section contained a chart area with space for three people to chart and a sink and work station for the preparation of medicines. They were so located that three patient sections could be serviced from each. A utility area was also located in the corridor for dirty clean-up. An additional workroom was provided containing a walk-in closet for bulk storage, equipment and supply storage cabinets, stove and refrigerator. This room, too, was provided with windows so that the nurse working in the room could view the whole unit.

These preliminary ideas were submitted to an architect for his refinement and location of plumbing and electrical services. The architect was able to meet the specifications without any changes. There were some misgivings about the "island" work stations because of the amount of space left in the corridor for the moving of beds. On paper the beds and carts could be moved from the unit and from cubicle to cubicle if needed, but barely.

Up to this point the planning had been done by a few people. When the architectural sketches were made, meetings were held with representatives of the medical staff. First, a meeting with Medicine, its sub-specialities and pediatrics was held. Following this was a meeting with general surgeons, obstetricians and other specialty surgeons. Each meeting generated suggestions about equipment but the basic layout was not changed.

A third meeting was held with a committee representing all groups selected by the executive committee. The agenda included a discussion of the physical layout, equipment, selection and policies on admission and dismissal. The proposed physical layout was well received. The primary discussion centered around policy development. The men concerned with internal medicine expressed more than mere doubt in combining medical intensive care with surgical recovery. Recognizing that the physical layout was designed for the varying types of intensive care, they questioned the ability of surgically oriented nurses to do justice to critical medical cases. It was their feeling that intensive care, medical or surgical, demanded specialization. This premise was not easily disproved. Several of the nurses, however, convinced them that the secret, as in so many instances, was inservice education. Basically, they submitted, critical care is critical care whether it is surgical or medical. The care of the unconscious patient, the care of tracheotomy, problems of airway—all these and more are fundamental to all intensive nursing. The job was to recognize specific requirements of each special service and to formulate an inservice program to supplement each nurse's knowledge. The physicians were *still* hesitant but did not wish to delay the construction.

To insure that equipment was where it was needed a special bedside unit was made. Designed as a permanent installation to serve two beds, it contained two oxygen outlets and three suction outlets (two gauge controlled and one straight). These five outlets were located on a control panel on the back of the unit 44 inches from the floor, along with a stationary blood pressure gauge. Jar holders were located above this area to hold solution jars where aspiration catheters could be soaked. A special recessed shelf was located at the bottom of the unit to hold three collecting bottles. Through an intricate mechanism in the back and out of the way, plastic tubing was run from the collecting bottles to conveniently located outlets on each side of the bedside unit to which could be attached the catheters. An adequate work surface was provided in front of the control panel and, just below, pull-out shelves gave additional work space if necessary. Storage drawers made up the remainder of the unit which contains four electrical outlets per bed.

Three major revisions were made in the drawings. To insure adequate electrical service separate electrical service leads of 30 amps each were provided for each bed exclusive of the power service for the lighting. Lighting was a big stumbling block. No light of a bedside or wall-mounted type could be found that gave sufficient lighting when the doctor needed it. Eight different styles were considered, tested and rejected. The final choice was a four-tube, ceiling-mounted fluorescent fixture, the top of which was hooded to eliminate ceiling reflected light. This fixture was suspended from the ceiling to the same heights as the rails of the draw curtains to prevent light from one bed spilling over to the next bed. Each fixture was separately switched so that the whole cubicle did not have to be lighted to treat or examine one patient. A restroom that was a part of the old area was retained to be remodeled with new fixtures including the installation of a bedpan washer and sanitizer.

With the decisions made, construction was started. When the old walls were wrecked and only the skeleton structure was left the new unit was laid out in chalk on the floor. Then with a bed of the size to be used in the department we checked how easily it was to walk and to move the bed about. Our one suspicion came true. The main corridor with the center island works stations was too narrow to get beds and carts from one end of the unit to the other. Those islands were changed. The medicine preparation area was split from the charting area on both islands and each section was moved to the side of the corridor. This necessitated closing in with a wall portions of several open-ended cubicles. Although view windows were provided in these walls a wider corridor with the original islands would be more efficient. No other major changes needed to be made in the unit.

This unit was opened in midsummer. The first patients cared for were those patients always cared for: the post-anesthesia patient and, for extended care, the serious post-operative patient. Medical intensive care was not fast in its growth. There was still the hesitancy evidenced in the first meetings with the medical staff. This hesitancy has diminished and this service has increased steadily with the rest.

From the beginning, a strong inservice education program was begun. The former recovery room staff, now the nucleus for the new staff, gave instruction in surgical intensive care. The entire staff worked out an educational program of medical intensive care with the assistance of the medical staff.

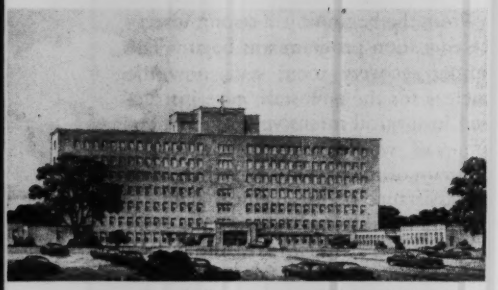
Thus far the medical staff has been well pleased with the facilities and service offered. The families of patients are most appreciative of this unit once its purpose is explained and they see its results.

It seems obvious but necessary to point out that the success of any such unit depends on the quality of its nursing care. Intensive care nursing is professional nursing at its best. The demands of critical patients necessitate the best work of the best nurses available. The nurse assigned to intensive care must work constantly to improve her skills and enlarge her knowledge or the best designed unit is worthless.

Lost Rivers, Arco, Idaho

Little Co. of Mary, Torrance, Calif.

Holy Redeemer, Meadowbrook, Pa.



Good Samaritan, West Islip, N.Y.

St. Mary's, Livonia, Mich.

Catholic Hospital Construction

by **DAN ROBERTS, St. Louis, Mo.**

THE CATHOLIC HOSPITALS of the United States are meeting the challenge of an expanding population by a progressive and continual program of expansion. Throughout the Catholic hospital system there is evidence of construction and expansion—in new hospitals, additions to existing facilities and the replacement or renovation of obsolete structures. If the current rate of construction activity is an indicator, Catholic hospitals will certainly keep apace, if not pull ahead, of the demands of the "expanding sixties."

A recent survey by the Catholic Hospital Association reveals that more than 240 projects are under construction or in the planning stage. These projects, already under construction, or for which plans have been announced, will add 15,894 beds to Catholic hospitals during the next two years, representing an expenditure of almost a half billion dollars.

On January 26, 1960 a tabulation of data on hand at the Catholic Hospital Association was made from information gathered from news reports, financial prospecti, and survey questionnaires returned from Diocesan hospital directors. Figure A is a summary of these projects:

During 1959, 90 projects were reported to have been completed. The net gain in bed capacity for 81 of these projects (data is not available on nine of the 90) amounted to 4,392 beds. Cost figures were available for 82 projects, amounting to $141,435,000. These 90 projects may be shown as follows:

New Hospitals	10
New Hospital (replacements)	6
Additions or New Wings	45
New Service Buildings	27
Renovations	2

Regionally, the East North Central States show the greatest construction activity in projects completed in 1959, projects under construction and projects on the drawing boards. This area, comprising the states of Ohio, Indiana, Illinois, Michigan and Wisconsin, completed 27 projects in 1959, adding 1,268 beds at an expenditure of more than $35,000,000. This region also leads in current construction ($80,-

000,000) and projects in planning ($68,000,000). The Middle Atlantic region gained 1,409 beds in 1959 as a result of 23 projects costing almost $35,000,000. Current construction on 22 projects in the West North Central States will add 1,266 beds at a cost of $44,000,000. Regional construction activity among Catholic hospitals is shown in Table 1.

New York State led the country in both expenditures ($16,500,000) and number of projects completed (12) in 1959. Pennsylvania's seven projects added 662 beds to existing facilities. Colorado also was active during 1959, adding 445 beds at a cost of $15,500,000. Table 2 presents a state and regional breakdown of projects completed during the past year.

Figure A	Number of Projects	Net Bed Gain	Cost
Completed in 1959	90	4,392	$141,435,000
Under Construction 12/31/59	115	7,275	234,421,000
Planned or in planning stage	123	8,619	236,816,000

In terms of projects under construction, Illinois is the most active state with 15 projects totaling almost $50,-

Table I. Catholic Hospital Construction Projects By Region

	NUMBER OF PROJECTS REPORTED			NET BED GAIN REPORTED			COST REPORTED		
	Completed 1959	Under Construction	Planned	Completed 1959	Under Construction	Planned	Completed 1959	Under Construction	Planned
New England	0	8	2	0	328	50	0	$13,533,000	$7,500,000
Middle Atlantic	23	19	14	1,409	705	811	$34,742,000	19,809,000	27,037,000
South Atlantic	6	5	14	17	585	1,329	6,200,000	12,280,000	33,960,000
East North Central	27	37	29	1,268	2,120	2,313	35,750,000	80,103,000	68,313,000
East South Central	4	4	3	255	230	249	11,650,000	5,642,000	2,850,000
West North Central	13	22	20	331	1,266	980	17,052,000	44,174,000	25,500,000
West South Central	5	7	9	403	996	452	12,004,000	30,064,000	13,350,000
Mountain	5	8	10	455	538	921	15,764,000	16,683,000	22,775,000
Pacific	7	5	22	254	507	1,514	8,273,000	12,133,000	35,531,000
Total U. S.	90	115	123	4,392	7,275	8,619	$141,435,000	$234,421,000	$236,816,000
Number of Projects for which figures were available				81	100	93	82	103	99
Number of projects for which figures were not available				9	15	30	8	12	24
Total Number of Projects Reported				90	115	123	90	115	123

Table 5. Major Catholic Hospital Projects Completed in 1959 ($2,000,000 or over)

	Hospital	Type of Project	Net Bed Gain	Cost
Colorado Springs, Colo.	Glockner-Penrose	New Hospital (R)	325	$8,500,000
Pueblo, Colo.	St. Mary-Corwin	New Hospital (R)	120	7,000,000
West Islip, N. Y.	Good Samaritan	New Hospital	175	6,000,000
Lexington, Ky.	St. Joseph	New Hospital (R)	(NA)	5,650,000
Des Moines, Iowa	Mercy	New Wing	(NA)	4,750,000
Baton Rouge, La.	Our Lady of the Lake	New Wing	225	4,500,000
New Brunswick, N. J.	St. Peter's	New Wings	80	4,500,000
Fort Worth, Texas	St. Joseph's	New Wing	40	4,026,000
Chester, Pa.	Sacred Heart	New Hospital (R)	208	4,000,000
Torrance, Calif.	Little Company of Mary	New Hospital	150	3,500,000
Chicago Heights, Ill.	St. James	New Wing	129	3,500,000
Livonia, Mich.	St. Mary	New Hospital	180	3,500,000
Meadowbrook, Pa.	Holy Redeemer	New Hospital	216	3,500,000
Milwaukee, Wisc.	St. Mary's	New Wing	173	3,500,000
Cedar Rapids, Iowa	Mercy	New Wing	103	3,400,000
Washington, D. C.	Georgetown Univ.	Diagnostic Building	0	3,045,000
Kankakee, Ill.	St. Mary's	New Wing	100	3,000,000
Cincinnati, Ohio	Good Samaritan	New Facilities Wing	0	3,000,000
Memphis, Tenn.	St. Joseph	New Wing	160	3,000,000
Chicago, Ill.	Frank Cuneo Memorial	New Children's Wing	140	2,500,000
Poughkeepsie, N. Y.	St. Francis	New Wing	117	2,500,000
Jeannette, Pa.	Jeannette District Memorial	New Hospital	99	2,500,000
Moorhead, Minn.	St. Ansgar	New Wing	61	2,157,000
Lansing, Mich.	St. Lawrence	New Wing	(NA)	2,000,000
Saginaw, Mich.	St. Mary's	New Wing	66	2,000,000
Harrison, N. Y.	St. Vincent (Westchester)	New Wing	105	2,000,000

(R) Replaces existing facilities (NA) Data not available

000,000, and a new-bed gain of 1,374. Likewise, Illinois is planning to spend another $34,000,000 to add another 1,320 beds. California is also active in planning, with 18 projects costing $29,000,000 and involving 1,265 beds. A state-by-state analysis of projects in process and projects in planning is shown in Table 3.

The Archdioceses of New York, Chicago, Philadelphia, Denver, Cincinnati and New Orleans all completed projects totaling more than $5,000,000 each during 1959, as did the Dioceses of Pueblo, Covington and Rockville Center.

The largest bed gain was in the Archdiocese of Philadelphia, where new construction added 424 beds. The Archdiocese of Chicago leads in projects under construction with 645 new beds at a cost of $24,000,000. The Archdiocese of St. Louis has four projects under construction which will cost $20,000,000 and add 490 new beds to its hospital facilities. The Archdiocese of Los Angeles has plans for 11 new projects, involving $21,000,000,—715 new beds, and three new hospitals. Table 4 is a listing, from available data, of Catholic hospital construction activity in each diocese.

Major projects of $2,000,000 or more, completed during 1959, numbered 26.

It should be emphasized that the accompanying tables include only information for which data is currently available. In the case of the 90 projects completed in 1959, bed-gain data is available on only 81 projects; cost data is available on only 82 projects. Likewise, of the 115 projects reported under construction, no bed-gain data is available for 15, no cost data for 12. Again,—of the 123 projects in planning, bed-gain data is lacking for 30 projects; cost data lacking for 24. No doubt, there are other projects for which no information has been received. The tabulations shown are merely a synthesis of *available data.* Projections to include omissions have not been attempted. A conservative estimate might place the actual totals between 10 per cent and 15 per cent higher than the reported totals.

From the foregoing it is evident that the Catholic hospitals in the United States are a dynamic factor in the nation's growth, welfare, health and economy. Where the Catholic hospitals are concerned, the challenge of the "expanding sixties" will meet its match. ★

TABLE 2. Catholic Hospital Construction Projects by State and Region

	PROJECTS COMPLETED IN 1959		
	Number Reported	Net Bed Gain Reported*	Cost Reported**
NEW ENGLAND			
Maine	0	0	0
New Hampshire	0	0	0
Vermont	0	0	0
Massachusetts	0	0	0
Rhode Island	0	0	0
Connecticut	0	0	0
TOTAL NEW ENGLAND	0	0	0
MIDDLE ATLANTIC			
New York	12	549	$16,492,000(1)
New Jersey	4	198(1)	6,450,000(1)
Pennsylvania	7	662	11,800,000(3)
TOTAL MIDDLE ATLANTIC	23	1,409(1)	$34,742,000(5)
SOUTH ATLANTIC			
Delaware	0	0	0
Maryland	0	0	0
District of Columbia	1	0	3,045,000
Virginia	1	0(1)	1,750,000
North Carolina	0	0	0
South Carolina	1	17	105,000
Georgia	1	0	600,000
Florida	1	0	200,000
West Virginia	1	0	500,000
TOTAL SOUTH ATLANTIC	6	17(1)	$6,200,000
EAST NORTH CENTRAL			
Ohio	9	274(2)	$9,950,000(1)
Indiana	1	45	100,000
Illinois	8	481	13,200,000
Michigan	3	246(1)	7,500,000
Wisconsin	6	222	5,000,000
TOTAL EAST NORTH CENTRAL	27	1,268(3)	$35,750,000(1)
EAST SOUTH CENTRAL			
Kentucky	3	95(1)	8,650,000
Tennessee	1	160	3,000,000
Alabama	0	0	0
Mississippi	0	0	0
TOTAL EAST SOUTH CENTRAL	4	255(1)	$11,650,000
WEST NORTH CENTRAL			
Minnesota	2	61(1)	3,657,000
Iowa	3	148(1)	9,750,000
Missouri	5	87	1,923,000
North Dakota	1	35	1,000,000
South Dakota	0	0	0
Nebraska	1	0	722,000
Kansas	1	0	NA(1)
TOTAL WEST NORTH CENTRAL	13	331(2)	$17,052,000(1)
WEST SOUTH CENTRAL			
Arkansas	0	0	0
Louisiana	2	225	5,078,000
Oklahoma	0	0	0
Texas	3	178	6,926,000
TOTAL WEST SOUTH CENTRAL	5	403	$12,004,000
MOUNTAIN STATES			
Montana	1	0	4,000
Idaho	1	10	260,000
Wyoming	0	0	0
Colorado	2	445	15,500,000
New Mexico	1	0	NA(1)
Arizona	0	0	0
Utah	0	0	0
Nevada	0	0	0
TOTAL MOUNTAIN STATES	5	455	$15,764,000(1)
PACIFIC STATES			
Washington	0	0	0
Oregon	1	27	1,113,000
California	5	199(1)	6,300,000
Alaska	0	0	0
Hawaii	1	28	860,000
TOTAL PACIFIC STATES	7	254(1)	$8,273,000
TOTAL U. S.	90	4,392(9)	$141,435,000(8)

*Figures in parentheses indicate number of projects reported, but for which bed capacity figures were not available, and are not included in the totals shown for Net Bed Gain Reported.

**Figures in parentheses indicate number of projects reported, but for which cost figures were not available, and are not included in the totals shown for Cost Reported.

NA—Not Available.

TABLE 3. Catholic Hospital Construction Projects by State and Region

	PROJECTS UNDER CONSTRUCTION 12/31/59			PROJECTS PLANNED OR IN PLANNING STAGE		
	Number Reported	Net Bed Gain Reported*	Cost Reported**	Number Reported	Net Bed Gain Reported*	Cost Reported**
NEW ENGLAND						
Maine	1	100	$2,500,000	0	0	0
New Hampshire	0	0	0	0	0	0
Vermont	1	NA(1)	1,500,000	0	0	0
Massachusetts	4	NA(2)	2,900,000(1)	1	NA(1)	$2,500,000
Rhode Island	1	100	2,500,000	0	0	0
Connecticut	1	128	4,133,000	1	50	5,000,000
TOTAL NEW ENGLAND	8	328(3)	$13,533,000(1)	2	50(1)	$7,500,000
MIDDLE ATLANTIC						
New York	7	207(1)	4,623,000(3)	9	255(4)	15,200,000(4)
New Jersey	6	120(1)	4,541,000	3	336	5,857,000
Pennsylvania	6	378(2)	10,645,000(1)	3	260	6,700,000(1)
TOTAL MIDDLE ATLANTIC	19	705(4)	$19,809,000(4)	15	851(4)	$27,757,000(5)
SOUTH ATLANTIC						
Delaware	0	0	0	0	0	0
Maryland	2	420	8,000,000(1)	2	381	14,000,000
District of Columbia	1	40	720,000	0	0	0
Virginia	0	0	0	2	NA(2)	300,000(1)
North Carolina	0	0	0	1	100	1,950,000
South Carolina	1	0	60,000	3	40(2)	2,250,000(1)
Georgia	0	0	0	1	150	4,000,000
Florida	0	0	0	2	450	6,500,000
West Virginia	1	125	3,500,000	2	168	4,240,000
TOTAL SOUTH ATLANTIC	5	585	$12,280,000(1)	13	1,289(4)	$33,240,000(2)
EAST NORTH CENTRAL						
Ohio	5	109(1)	6,564,000	7	392(2)	9,478,000(1)
Indiana	5	285(1)	9,500,000(2)	2	96(1)	6,318,000
Illinois	15	1,374(1)	48,739,000(1)	11	1,320(3)	34,240,000(3)
Michigan	3	113(1)	5,625,000	1	145	3,200,000
Wisconsin	9	239	9,675,000(1)	8	360(2)	15,077,000(2)
TOTAL EAST NORTH CENTRAL	37	2,120(4)	$80,103,000(4)	29	2,313(8)	$68,313,000(6)
EAST SOUTH CENTRAL						
Kentucky	0	0	0	1	0	450,000
Tennessee	2	230	4,500,000	1	49	400,000
Alabama	0	0	0	0	0	0
Mississippi	2	0	1,142,000	1	200	2,000,000
TOTAL EAST SOUTH CENTRAL	4	230	$5,642,000	3	249	$2,850,000
WEST NORTH CENTRAL						
Minnesota	3	417	9,900,000	2	152	1,500,000(1)
Iowa	0	0	0	6	159(1)	5,682,000
Missouri	13	590(2)	26,218,000(1)	2	137	1,000,000(1)
North Dakota	1	61	2,250,000	1	69	1,798,000
South Dakota	0	0	0	2	NA(2)	1,730,000
Nebraska	0	0	0	4	258(1)	9,040,000
Kansas	5	198	5,806,000	3	205(1)	4,750,000(1)
TOTAL WEST NORTH CENTRAL	22	1,266(2)	$44,174,000(1)	20	980(5)	$25,500,000(3)
WEST SOUTH CENTRAL						
Arkansas	1	0	1,114,000	0	0	0
Louisiana	1	24	250,000	4	248(1)	6,000,000
Oklahoma	1	225	8,000,000	1	96	1,800,000
Texas	4	747(2)	20,700,000(1)	4	108(2)	5,550,000
TOTAL WEST SOUTH CENTRAL	7	996(2)	$30,064,000(1)	9	452(3)	$13,350,000
MOUNTAIN STATES						
Montana	2	54	703,000	2	NA(1)	80,000(1)
Idaho	0	0	0	0	0	0
Wyoming	0	0	0	0	0	0
Colorado	2	184	6,500,000	5	522	14,750,000(2)
New Mexico	1	0	480,000	1	44	5,000,000
Arizona	1	125	3,000,000	1	180	2,945,000
Utah	1	100	4,500,000	0	0	0
Nevada	1	75	1,500,000	1	175	NA(1)
TOTAL MOUNTAIN STATES	8	538	$16,683,000	10	921(1)	$22,775,000(4)
PACIFIC STATES						
Washington	1	125	300,000	2	46(1)	1,250,000(1)
Oregon	0	0	0	1	78	1,800,000
California	4	382	11,833,000	18	1,265(3)	28,981,000(3)
Alaska	0	0	0	1	125	3,500,000
Hawaii	0	0	0	0	0	0
TOTAL PACIFIC STATES	5	507	$12,133,000	22	1,514(4)	$35,531,000(4)
TOTAL U. S.	115	7,275(15)	$234,421,000(12)	123	8,619(30)	$236,816,000(24)

*Figures in parentheses indicate number of projects reported, but for which bed capacity figures were not available, and are not included in the totals shown for Net Bed Gain Reported.

**Figures in parentheses indicate number of projects reported, but for which cost figures were not available, and are not included in the totals shown for Cost Reported.

NA—Not Available.

Nebraska	Omaha	1	0	722,000	0	0	0	2	258	7,500,000
Nebraska	Lincoln	0	0	0	0	0	0	1	0	350,000
Nebraska	Grand Island	0	0	0	0	0	0	1	NA	1,190,000
Nevada	Reno	0	0	0	1	75	1,500,000	1	175	NA
New Jersey	Newark	1	NA	NA	3	0	2,446,000	2	186	4,357,000
New Jersey	Trenton	2	80	4,565,000	1	0	25,000	0	0	0
New Jersey	Patterson	1	118	1,885,000	1	120	2,000,000	0	0	0
New Jersey	Camden	0	0	0	1	NA	70,000	1	150	1,500,000
New Mexico	El Paso (Texas)	1	0	NA	0	0	0	0	0	0
New Mexico	Santa Fe	0	0	0	1	0	480,000	1	44	5,000,000
New York	New York	6	284	7,812,000	2	NA	NA	3	20	5,200,000
New York	Buffalo	3	0	2,180,000	2	181	1,300,000	2	200	5,000,000
New York	Ogdensburg	1	0	500,000	0	0	0	0	0	0
New York	Rockville Center	1	175	6,000,000	0	0	0	0	0	0
New York	Albany	1	90	NA	1	0	700,000	0	0	0
New York	Brooklyn	0	0	0	1	26	1,000,000	1	NA	3,000,000
New York	Rochester	0	0	0	0	0	0	2	NA	NA
New York	Syracuse	0	0	0	1	0	1,623,000	1	35	2,000,000
North Carolina	Raleigh	0	0	0	0	0	0	1	100	1,950,000
North Dakota	Fargo	1	35	1,000,000	0	0	0	0	0	0
North Dakota	Bismark	0	0	0	1	61	2,250,000	1	69	1,798,000
Ohio	Cincinnati	4	174	5,200,000	0	0	0	3	346	3,850,000
Ohio	Columbus	2	NA	2,250,000	0	0	0	2	46	1,811,000
Ohio	Cleveland	2	100	1,000,000	2	NA	2,650,000	1	NA	2,900,000
Ohio	Toledo	1	0	1,500,000	1	0	755,000	1	0	917,000
Ohio	Steubenville	0	0	0	1	109	3,000,000	0	0	0
Ohio	Youngstown	0	0	0	1	0	159,000	0	0	0
Oklahoma	Oklahoma City	0	0	0	1	225	8,000,000	1	96	1,800,000
Oregon	Baker	1	27	1,113,000	0	0	0	1	78	1,800,000
Pennsylvania	Philadelphia	2	424	7,500,000	0	0	0	1	35	NA
Pennsylvania	Pittsburgh	1	81	1,800,000	1	300	6,600,000	1	0	700,000
Pennsylvania	Greensburg	1	99	2,500,000	0	0	0	0	0	0
Pennsylvania	Scranton	2	30	NA	2	0	845,000	0	0	0
Pennsylvania	Erie	1	28	NA	2	78	500,000	0	0	0
Pennsylvania	Harrisburg	0	0	0	1	NA	2,700,000	1	225	6,000,000
Rhode Island	Providence	0	0	0	1	100	2,500,000	0	0	0
South Carolina	Charleston	1	17	105,000	1	0	60,000	3	40	2,250,000
South Dakota	Sioux Falls	0	0	0	0	0	0	1	NA	1,200,000
South Dakota	Rapid City	0	0	0	0	0	0	1	NA	530,000
Tennessee	Nashville	1	160	3,000,000	2	230	4,500,000	1	49	400,000
Texas	Dallas	1	40	4,026,000	1	530	13,000,000	1	90	1,500,000
Texas	Galveston	1	38	1,200,000	1	217	6,500,000	1	18	300,000
Texas	San Antonio	1	100	1,700,000	0	0	0	0	0	0
Texas	Amarillo	0	0	0	2	NA	1,200,000	0	0	0
Texas	Corpus Christi	0	0	0	0	0	0	2	NA	3,750,000
Utah	Salt Lake City	0	0	0	1	100	4,500,000	0	0	0
Vermont	Burlington	0	0	0	1	NA	1,500,000	0	0	0
Virginia	Richmond	1	NA	1,750,000	0	0	0	2	NA	300,000
Washington	Spokane	0	0	0	1	125	300,000	0	0	0
Washington	Seattle	0	0	0	0	0	0	2	46	1,250,000
West Virginia	Wheeling	1	0	500,000	1	125	3,500,000	2	168	4,240,000
Wisconsin	Milwaukee	5	196	4,638,000	7	141	5,838,000	5	175	10,337,000
Wisconsin	Green Bay	1	26	362,000	1	50	3,000,000	1	25	250,000
Wisconsin	La Crosse	0	0	0	1	48	837,000	1	110	3,000,000
Wisconsin	Superior	0	0	0	0	0	0	1	50	1,490,000
TOTAL REPORTED		90	4,392	$141,435,000	115	7,275	$234,421,000	123	8,619	$236,816,000

*Based on information received to January 26, 1960.

TABLE 4. Catholic Hospital Construction Projects by Diocese*

State	Diocese	COMPLETED IN 1959			UNDER CONSTRUCTION 12/31/59			PLANNED OR PLANNING STAGE		
		Number Reported	Net Bed Gain Reported	Cost Reported	Number Reported	Net Bed Gain Reported	Cost Reported	Number Reported	Net Bed Gain Reported	Cost Reported
Alaska	Anchorage	0	0	0	0	0	0	1	125	$3,500,000
Arizona	Tuscon	0	0	0	1	125	$3,000,000	1	180	2,945,000
Arkansas	Little Rock	0	0	0	1	0	1,114,000	0	0	0
California	Los Angeles	3	199	4,350,000	1	250	5,000,000	11	715	20,981,000
California	San Francisco	2	NA	1,950,000	2	108	5,133,000	5	396	6,200,000
California	Monterey-Fresno	0	0	0	1	24	1,700,000	2	154	1,800,000
Colorado	Denver	1	325	8,500,000	1	100	5,000,000	4	502	13,750,000
Colorado	Pueblo	1	120	7,000,000	1	84	1,500,000	1	20	1,000,000
Connecticut	Hartford	0	0	0	1	128	4,133,000	1	50	5,000,000
D. C.	Washington	1	0	3,045,000	1	40	720,000	0	0	0
Florida	St. Augustine	1	0	200,000	0	0	0	1	350	4,000,000
Florida	Miami	0	0	0	0	0	0	1	100	2,500,000
Georgia	Atlanta	1	0	600,000	0	0	0	1	150	4,000,000
Hawaii	Honolulu	1	28	860,000	0	0	0	0	0	0
Idaho	Boise	1	10	260,000	0	0	0	0	0	0
Illinois	Chicago	5	269	7,800,000	6	645	23,913,000	6	470	10,890,000
Illinois	Springfield	2	112	2,400,000	3	175	10,900,000	1	200	3,900,000
Illinois	Joliet	1	100	3,000,000	0	0	0	1	300	10,000,000
Illinois	Peoria	0	0	0	3	242	5,226,000	2	320	8,700,000
Illinois	Belleville	0	0	0	1	72	1,700,000	0	0	0
Illinois	Rockford	0	0	0	2	240	7,000,000	1	30	750,000
Indiana	Evansville	1	45	100,000	1	0	1,500,000	0	0	0
Indiana	Lafayette	0	0	0	1	NA	NA	1	96	2,318,000
Indiana	Fort Wayne	0	0	0	1	125	4,000,000	1	NA	4,000,000
Indiana	Gary	0	0	0	1	100	4,000,000	0	0	0
Indiana	Indianapolis	0	0	0	1	60	NA	0	0	0
Iowa	Dubuque	1	103	3,400,000	0	0	0	2	50	1,750,000
Iowa	Davenport	0	0	0	0	0	0	3	109	3,486,000
Iowa	Sioux City	1	45	1,600,000	0	0	0	1	0	446,000
Iowa	Des Moines	1	NA	4,750,000	0	0	0	0	0	0
Kansas	Kansas City, Kansas	0	0	0	1	0	4,000	0	0	0
Kansas	Wichita	1	0	NA	2	53	2,077,000	1	55	1,500,000
Kansas	Salina	0	0	0	1	100	2,600,000	1	NA	NA
Kansas	Dodge City	0	0	0	1	45	1,125,000	1	150	3,250,000
Kentucky	Louisville	1	35	1,500,000	0	0	0	1	0	450,000
Kentucky	Covington	2	60	7,150,000	0	0	0	0	0	0
Louisiana	New Orleans	2	225	5,078,000	1	24	250,000	4	248	6,000,000
Maine	Portland	0	0	0	1	100	2,500,000	0	0	0
Maryland	Baltimore	0	0	0	2	420	8,000,000	2	381	14,000,000
Massachusetts	Boston	0	0	0	3	NA	2,500,000	1	NA	2,500,000
Massachusetts	Fall River	0	0	0	1	NA	400,000	0	0	0
Michigan	Detroit	1	180	3,500,000	0	0	0	0	0	0
Michigan	Lansing	1	NA	2,000,000	1	75	2,000,000	0	0	0
Michigan	Saginaw	1	66	2,000,000	1	NA	2,250,000	1	145	3,200,000
Michigan	Marquette	0	0	0	1	38	1,375,000	0	0	0
Minnesota	St. Paul	0	0	0	3	417	9,900,000	0	0	0
Minnesota	Crookston	2	61	3,657,000	0	0	0	0	0	0
Minnesota	Winona	0	0	0	0	0	0	2	152	1,500,000
Mississippi	Natchez	0	0	0	2	0	1,142,000	1	200	2,000,000
Missouri	St. Louis	2	80	1,600,000	4	490	20,328,000	2	137	1,000,000
Missouri	Kansas City-St. Joseph	1	0	158,000	3	NA	3,784,000	0	0	0
Missouri	Springfield-Cape Girardeau	2	7	165,000	6	100	2,106,000	0	0	0
Montana	Great Falls	1	0	4,000	1	14	100,000	2	NA	80,000
Montana	Helena	0	0	0	1	40	603,000	0	0	0

Family Reactions to Mental Illness

by **REV. ALOYSIUS H. SCHELLER, S.J.**
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THERE ARE SERIOUS GAPS in the knowledge of mental illness as well as in effective cures, if cures are possible at all. Yet, of all illnesses, there are perhaps none which have such unhappy effects on other members of the family as those accompanying the mental illness of one member of the family. Furthermore, mental illness is far more difficult to understand and accept than physical illness. The opinion is still common that if the mentally ill person "took hold of himself," if he made more of an effort to overcome his fears or anxieties, if he used more will power he could restore his mental health. There is actually as little possibility of the mentally ill person curing himself as there is of a person who is suffering from a cardiac condition curing his condition without treatment.

The lack of understanding of mental illness is one of the hindrances to more rapid treatment and cure of the mentally ill. Of all environmental factors, a good understanding of the mentally ill person is most essential. Families generally accept the physical illness of one of their members as something which, in the course of events, must at times be anticipated. Mental illness, however, carries a stigma with it and it may become a matter of embarrassment to other members of the family —who either try to ignore the illness or go to the extreme of gradually isolating themselves while the illness persists.

The situation is aggravated still more when the mentally ill person is the breadwinner or one upon whose income the family depends. The sick person finds it impossible to keep employment. He is released involuntarily or he leaves his work to the dismay or disappointment of the family who insist he would be better off if he were employed and had less time to "think about himself," and to brood over his worries and anxieties.

With the stimulus given by The United States Public Health Service, there is a tremendous increase in studies and research of mental illnesses; and the results are beginning to manifest themselves. It should not be surprising that some mental illnesses are as incurable as certain physical illnesses at this stage of knowledge. What does seem evident now is that for the effective treatment of the mentally ill person a complementary staff of personnel is essential. Contributions to an understanding and diagnosis, as well as treatment of mental illness, are made by the psychiatrist, the psychologist and the psychiatric social worker. Depending upon the variable circumstances, it may be the psychologist whose contribution is of the greatest help. At other times it may be the psychiatric social worker as well as the psychiatrist.

Assume that in a hypothetical situation the father of a family gradually "breaks down," as it is commonly stated. For reasons that do not seem apparent, a healthy 40-year-old man, the father of four or five children enjoying adequate economic security, begins to manifest symptoms of anxiety and fear. He reveals them to a devoted wife who admits that her husband looks pale and has not been eating well or sufficiently. Despite her pleas, the condition of the father grows worse. His employer notices an apathy, an unaccountable lack of interest, and finally an irresponsible manner of conduct. The employer speaks to him without effect, then issues the ultimatum that unless his work is raised to his capacities and commensurate with his salary he will be dismissed from employment. Dismissal almost inevitably follows.

The mother of the family tries to understand her husband's behavior and bears with him in these early stages of difficulty; but the blow comes when, on an occasion, he returns home in a drunken condition and follows this up with abusive actions and talk directed to all members of the family. It is too much. Something must be done. Often, and prudently, the wife will speak to her pastor, who in turn agrees to speak to the husband. By this time the good man is very repentant and regretful of his actions to the family. He may actually show excessive grief and tend to cry at the very thought of the manner in which he is acting. The man is mentally sick and should be referred to a competent psychiatrist for help.

Meanwhile at home there is no weekly income. Before long savings are exhausted and the strain on a devoted mother and wife comes closer to a breaking point. The children notice the impatience of their mother and soon an entire family is suffering from the consequences of one sick parent. It is hard for the family to explain to well-meaning neighbors what is happening to their father and husband. It is a prudent wife who acts as quickly as the one in this hypothetical situation. For if allowed to become more serious, a mentally sick father may and does all too often become so despondent that he tries to end his own life. Mental illness, as physical illness, is more effectively diagnosed if it is detected and treated in its early stages. The delay before seeking adequate professional help can be measured in un-

fortunate results for the mentally ill person and his family.

The psychiatrist frequently suggests that hospitalization is in order for the mentally ill patient. One of the factors urging this judgment is the possibility of serious damage to the patient himself. Too often a fearful vigil may be prolonged in the home because it is generally thought that, as in other minor illnesses, a cure will be sudden and complete. The treatment of mental illness is generally of long duration if it is to be effective. In certain illnesses shock treatment can bring a person to normalcy in a relatively short time, but only in exceptional cases does shock treatment alone produce the desired effect.

The Cause is Found

The first problem of the psychiatrist and his complementary staff is to diagnose the mental illness and factors that have contributed to bring about the anxieties, the alcoholism and other irregular behavior traits of the patient. The psychiatrist, who is also a doctor of medicine, gets no help from x-rays or laboratory findings. He must somehow make a diagnosis from the symptoms which are manifest, from the social history of the patient and from an interpretation of symptoms as unconscious influences on the patient's behavior. Psychiatrists, and especially psychoanalysts, trace "the meaning of behavior" very largely to the influence of the unconscious on a person. The anxieties which come to the surface, the tensions, the alcoholism are symptoms of this influence of which the patient is generally unaware—he cannot rid himself of them because he does not know their origin or because he is unwilling to face them.

If, however, the probing or the methods of psychiatry can uncover these hidden or unconscious influences and bring them out into the open, they can be dealt with. Dr. Karl Stern gives this good illustration: A young soldier returned to the shores of England after the horrible ordeal at Dunkirk. The young man was blind, but on examination there was no evidence whatever of organic lesion in either eye. In psychiatric treatment, he revealed the horrors he had to look upon in the evacuation at Dunkirk and the efforts he made to push from his memory the scenes of carnage and slaughter. He had suppressed the memory of the tragic hours. When it was all laid before him in treatment, he shrieked and screamed in agony; but in the end he overcame his hysterical dread and his sight was restored. Not every experience is a dramatic as this, but the phenomenal reaction to insight which the psychiatrist tries to give his patient is not uncommon in less aggravated, but none the less very disturbing, behavior.

The Family is Important

During the period of treatment and convalescence of the mentally ill patient, there are scores of details to watch and to resolve. The psychiatrist tries to deepen his understanding of the particular illness, the complementary staff of psychologists and psychiatric social workers try to patch together details of the onset of the illness and any factor which may be involved in the etiology. The patient is viewed in his totality. The whole person is considered; and this necessarily includes those nearest to him, his family. It is the function, among others, of the psychiatric social worker to offer psychological support and to indicate the resources for financial help, when necessary, to the family. An additional and important function of the psychiatric social worker is to contribute to the better knowledge of family relationships and factors abetting the diagnosis as well as the treatment of the patient.

In her interview with the wife and mother of the patient, the psychiatric social worker may find that she is dealing with a dominating woman whose own ambitions exceed those of her husband, as well as his capacity. It may be too delicate a matter to discuss in early interviews, but the time will come when some member of the staff must give the good woman an insight into the harm she is causing by pushing her husband beyond his own capacities and ambitions. In a day when material success means so much, there is a real tendency in this direction and while the wife may consider herself completely innocent of any harm to her husband, she may have been at least one of the precipitating factors in his breakdown.

It is not the purpose of the social worker to indicate bluntly the effects which are objectively real in such circumstances. Since people can only change themselves, they will not do so until they themselves possess or gain the insight to recognize their own behavior and the effect it has on others. How commonly one hears it said: "I never intended to leave that impression, to give that impression." The fact is that such an impression was given, and the guilty party can either ignore the assertion that such an impression was given or he can strive for a better understanding of himself, which is another way of saying he can gain better insight into himself. Sometimes the psychiatric social worker will find a family willing to make sacrifices of a generous nature, to offer Masses and prayers for the recovery of the sick member of their family, but in the one important area of acceptance which is simply a charitable or loving understanding of him, there is no advance. There are equally large numbers of families, and the author has seen them, in which the mentally ill patient becomes the focus of devoted attention, actually drawing members of the family together, psychologically as well as spiritually. There is no stronger bond than that of love and charity.

Psychodrama may Help

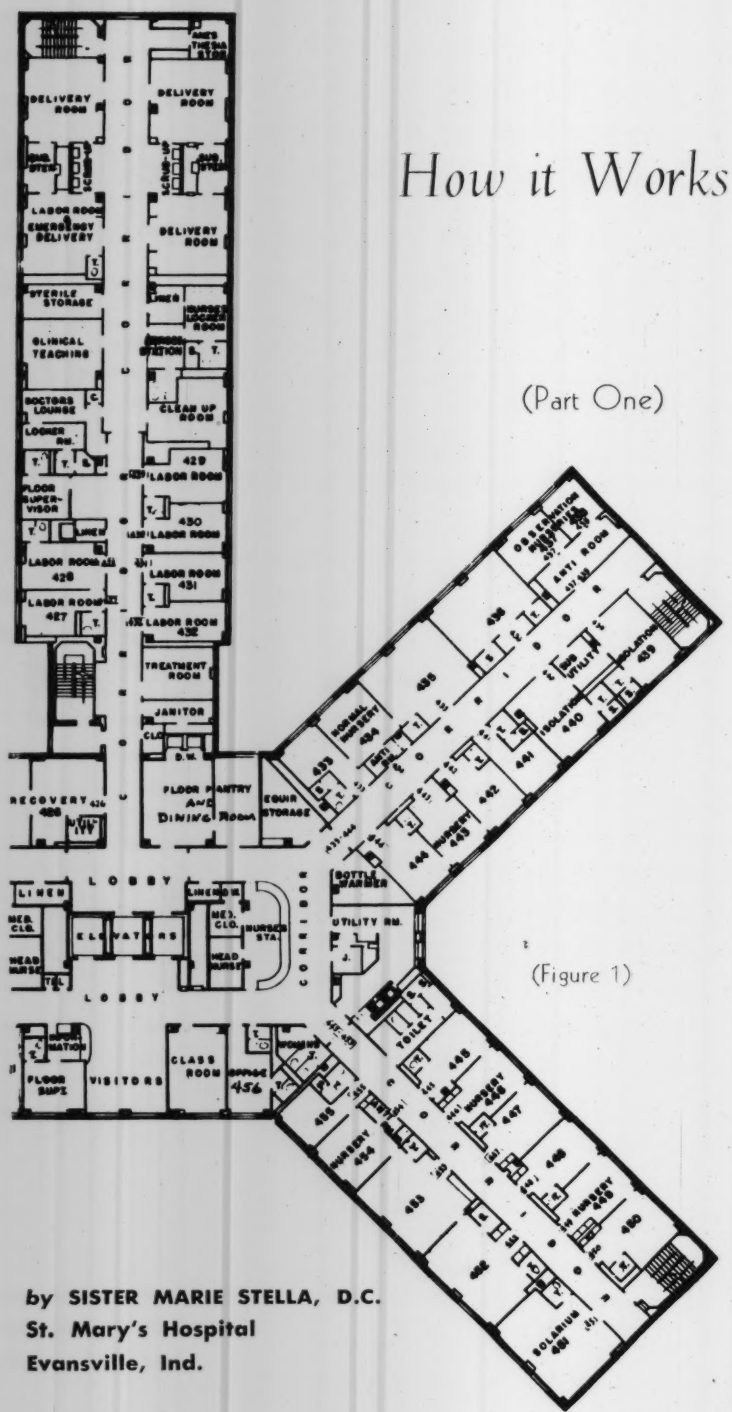
While the psychiatric social worker continues to give attention to the family, the psychiatrist and psychologist are working more directly with the patient, and through the pooling of information new clues are brought forward both in the diagnosis and treatment of the mentally sick person. The progress may not be rapid; yet when it is not a hopeless situation it may take a considerable amount of time and the use of different techniques to uncover the basic factors of the mental illness. One interesting and more recently developed technique is that of psychodrama in which the patient takes a part in an impromptu play with the psychitrist and psychologist or the social worker and other patients, each playing different roles. The drama is devised with as much resemblence to the patient's own family and environment as possible. It is replayed with the patient taking a different part each time. The expectation is that the patient will reveal feelings towards members of his family or others in his life who had a happy as well as a damaging effect on his mental condition. It is another method of uncovering hidden factors which the patient actually is unwilling to face or that he has suppressed for one reason or another. Psychodrama has been effective; and in

(Concluded on page 142)

FAMILY-CENTERED MATERNITY CARE

How it Works

(Part One)



(Figure 1)

by SISTER MARIE STELLA, D.C.
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Evansville, Ind.

WHAT DO WE MEAN by good obstetrical care? Recently much attention has been given to the progress made in reducing mother and infant mortality. In the United States in 1935 about 12,000 mothers died from childbirth or related causes while, in 1953, there were only 2,000 such deaths. These are approximate figures but they tell the story. In 1935 about 120,000 infants were lost, while there were only about 108,000 infant deaths in 1953. The reduction in infant mortality over the 20-year period amounted to approximately 10 per cent—a dramatic reduction indeed. Yet almost all of the gain was in the infant group one week old or older, while the *mortality of infants under one week remained comparatively stable!*[1] This points directly to the importance of the period before birth and immediately after birth and suggests that infant care cannot be separated from maternal care.

It is essentially from this standpoint that the family-centered plan of maternity care at St. Mary's Hospital, Evansville, Indiana has come into being, for that plan places increased emphasis upon the pre-natal and the immediate post-natal period, not merely upon the assurance of a safe delivery and an early dismissal.

It is not the intent of this program to eliminate any approach to conventional obstetrical care which might have contributed to the progress implied in the statistics just cited. On the contrary, the objective has been simply to rearrange existing methods, to incorporate additional methods and to develop *good* obstetrical care so that the total well-being of both mother and infant is ensured. *Total* means not only physical safety but also social, psychological and spiritual well-being of the *total family group,* including the mother, the infant and the father.

A program of family-centered maternity care demands consideration of very basic relationships which often have been neglected in the "scientific approach." When severe epidemic occurred in newborn nurseries, regulations restricting visitors to maternity departments seemed necessary. Frequently even members of the families were restricted. Today, in most hospitals, only husbands may visit. The father may or may not get a look at his baby. Sometimes the mother is severely scolded if she merely attempts to unwrap the baby, count his toes or

look at the birthmark, about which she probably has been told nothing. It was in just this type of situation that hospital nursing began to lose sight of the family as a unit. Paradoxically, it was while this loss was occurring that more and more mothers were coming to the hospital to deliver their babies. In so doing they were forced into a very *unnatural* situation, yet we in the hospital expected them to adjust to it. Thus, in losing touch with the family, we lost our family touch.

When the proposal was first made that hospitals disband the central nursery and include the family unit plan in their obstetrical service, much resentment was aroused. Even today, to overcome the idea of the necessity for central nurseries takes a real brainwashing. It seems that people like to be mechanical and it seems that this is true of nurses in particular. We appear at least *to like routines* and, of course, routines are just *substitutes for thinking.* In conventional hospital maternity care there is danger of making techniques, routines, procedures, and the like both the chief interest and the chief goal. The nurse gives the orders and the patient is expected to follow them. A completely different orientation is required for the family-centered plan of care. For the author the privilege of working as a student of nurse midwifery for one year in the homes of families in Santa Fe, New Mexico, under the direction of the Catholic Maternity Institute, made clear the value of family-centered care. It was an experience which gave insight into the meaning of the family as a living, inter-acting group within the home environment.

How many nurses really stop to think about this relationship of family members? A year spent in this setting —a setting which relates maternity care to the family of which, by nature, it is an inseparable part—opens the mind to basic principles, overlooked and perhaps almost forgotten. It is an experience which forces the nurse to think about her role in relation to the beauty of the family, and about the responsibility of the hospital in its relation to the family. In Santa Fe, nurses knock at the door of the patient's home and wait outside until asked to come in. Once inside, nothing in the home is used until permission has been asked. In this setting nurses give care to people rather than blind attention to routines and traditions. This is precisely what hospitals claim as their reason for being. The family-centered plan of maternity care at St. Mary's Hospital described below represents an attempt to bring the home atmosphere into the hospital situation and to replace attention to routines with care for the family unit.

First of a series of four articles adapted for publication in cooperation with P. H. S. Research Project W-44, (Division of Hospital and Medical Facilities, Public Health Service), currently underway at St. Mary's Hospital, Evansville, Indiana.

The floor plan of St. Mary's obstetrical service consists of three clearly defined areas: 1. the labor and delivery suite, 2. post-partum wings, 3. centrally located utility and service areas. These three areas are functionally as well as physically defined, since the obstetrical service was originally designed in accord with plans to adopt the family-centered programs. Although design contributes to the ease with which the program can be achieved in an institutional setting, the success of the program is not dependent upon structural plan. Family centered care is built upon learning and teaching relationships and a reinterpretation of function for all those who participate.

The labor and delivery suite occupies the long north wing which contains six private labor rooms, four delivery rooms, a clinical teaching room, a treatment room and a recovery room as well as staff accommodations and storage space. This wing opens directly from the elevators. The two post-partum wings assigned to obstetrics contain private and semi-private rooms, 4-bed units, small normal nurseries and observation nurseries. The proximity of the normal nurseries to patient rooms is important for, as the diagram indicates (Fig. 1,) the normal nursery is placed so that it will open into the two immediately adjacent patient rooms. For example, a small nursery, room 446, opens directly into two semi-private rooms, 447 and 445, and will accommodate four babies, two from each of the semi-private rooms. Another nursery (Room 454) opening directly into a private room (Room 455) and into two four-bed nursing units (Rooms 452 and 453) will accommodate nine babies. This orientation is carried out throughout the post-partum area. As the diagram indicates, the premature and observation nursery is located at the end of the northeast wing with a small ante-room where circumcisions and baby examinations are performed. The third area, i.e., the service area, consists of the nurse station, utility rooms, linen closets, a floor pantry and, most important, a maternity floor dining room.

"Happier Childbirth Experiences for 'Mr. and Mrs. Smith'"

When Mrs. Smith arrives at the hospital she is directed immediately to the labor room. Normally she is not taken to the admitting office but rather goes directly to the labor room area. Her husband accompanies her. Admitting details are handled by him either in the admitting office or in the labor room after Mrs. Smith has settled down. During labor Mrs. Smith is never left alone. Mr. Smith is permitted to stay with his wife throughout labor, and if by chance it is necessary for him to leave, a nurse or aide will replace him. Few rules and regulations govern the family-centered plan. There is one, however, which is adhered to strictly, i.e., that the mother never be left alone during labor. All nursing personnel, both professional and non-professional, have had classes in the importance and meaning of providing support to a mother in labor. Over and above the formal education, this concept is taught on a continuing basis and is paramount to the successful operation of a family-centered program. Achieving this was understandably a very difficult task, since it meant the re-education of professional nurses, who are accustomed to staying behind the nursing unit desk. It meant showing them the importance of staying with the patient.

MOTHER AND FATHER arrive together on obstetrical floor, escorted by nurse. The same nurse who admits the group will remain directly in charge of mother throughout labor and delivery and, following delivery, will usually take mother and baby to recovery room and eventually to post-partum.

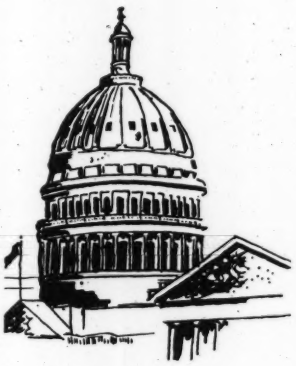
MOTHER IN LABOR ROOM with husband. During early stage of labor mother may remain up and about if she wishes, husband may remain with wife throughout the labor period. Presence of husband provides support and sense of security to mother. Mothers and fathers want this right, and deserve it.

It meant helping the nurse develop to the point where she could use this opportunity to teach the mother and thus realize the full importance of this educational experience for the mother and for herself as a nurse. In our illustration, (Fig. 3) Mrs. Smith has someone in the room with her, either Mr. Smith or/and one of the nursing personnel.

Pre-natal classes are offered both to mothers and fathers over a period of six weeks prior to delivery. If Mr. and Mrs. Smith have attended these classes, they are rather well-informed as to the normal processes which are occurring during the labor. In case the Smiths have not attended these classes, the nurse must extend her responsibility to meet their needs. This means that, during the labor period, the nurse's function will consist largely of direct explanation and instruction to the parents, of informing the parents about what is taking place, about breathing exercises to augment the labor process and about the role of the father in assisting the mother. There is a chair in the labor room which can be converted into a bed so that, if Mrs. Smith remains in labor for some time, her husband may remain with her. If he wishes, he may spend the entire day and night. Mr. Smith may even remain with his wife throughout delivery if he and Mrs. Smith so desire.

Mrs. Smith may choose how she prefers to deliver her baby. She may have a saddle-block anesthetic or she may have a general anesthetic. If she wishes no anesthetic, preferring instead to deliver the child by natural childbirth means, this is her privilege; the choice rests with her entirely. In the friendly and emotionally satisfying atmosphere achieved by allowing the father and mother to remain together throughout labor, we find that far less analgesia is needed. Frequently mothers will choose saddle-block anesthesia in preference to a general anesthetic. More and more mothers are beginning to request no anesthetic and it seems reasonable to suppose that the parents' understanding through both formal and informal teaching is a major contributory factor here.

(To be concluded next month)



Laws and Legislation

by GEORGE REED, LL.M., Associate Director • Legal Department, N.C.W.C. • Washington, D.C.

THE ADMINISTRATION HAS SUBMITTED a recommended budget for the Department of Health, Education, and Welfare. Its statement is prefaced by the observation that the expenditures of the Department for the fiscal year 1961 will exceed current fiscal expenditures by approximately one million dollars. Despite the fact that there is an over-all increase in the budget of H.E.W., health programs will receive less money during the coming fiscal year if the Congress adopts recommendations made by the President.

In the field of hospital construction $185,000,000 was appropriated for fiscal 1960. The new budget recommends an appropriation of $125,000,000. The amount requested for grants for hospital construction will assertedly provide enough grants-in-aid to assure development of general hospital beds sufficient to cover population increases, replacement of obsolescent beds and to provide for a reduction of approximately 6,000 beds in the cumulative backlog. This has been the average rate of reduction since the inception of the program. The probabilities are that the Congress will not limit its appropriation to the recommendation of the Administration. The Congress has consistently voted more money than the President has recommended. Undoubtedly the appropriation for fiscal 1961 will be close to $150,000,000.

The appropriation for grants for the construction of health research facilities for fiscal 1960 was $30,000,000. This year the Administration recommends an appropriation of $25,000,000. The total appropriation in 1960 for health research facilities and hospital construction was $265,087,000. This year the recommended appropriation is $180,099,000.

Appropriations to H.E.W. for 1960 were $400,000,000; the same amount is recommended for 1961. Within the appropriation for $400,000,000, approximately $281,000,000 will be spent directly for medical research. The balance will be devoted to training, dissemination of research result and related purposes.

A recent report indicates that there is still a substantial amount of money left from the appropriation of $50,000,000 for the construction of homes for nurses and for medical interns. The current rate of interest for 40-year loans for such projects is 3⅛ per cent. The prime interest rate established by the Federal Reserve Board is 5 per cent. Under the program administered by the Housing and Home Finance Agency, loans are limited to $500,000 unless evidence can be adduced demonstrating a special need for an additional loan. Projects are limited to 125 units.

One of the more encouraging developments in the health field during the last few months was the announcement by the Secretary of Health, Education, and Welfare, Mr. Arthur Flemming, that the Administration would propose legislation designed to provide broader grants to medical, dental and public health schools for medical and health related research and for research training programs. In letters to the President of the Senate and the Speaker of the House, Secretary Flemming requested that the Public Health Service Act be amended so that the Surgeon General will have authority to make grants for the support of basic research programs of various institutions in addition to grants now authorized to support specific research projects conducted by individuals. No new appropriation would be required. The funds would be secured by setting aside a certain percentage, not to exceed 15 per cent of the appropriations to the National Institutes of Health for research grants. This legislation would implement recommendations made to the Secretary by a group of consultants who have studied the whole problem of medical research. Also, the President's Science Advisory Committee has recommended that:

> Institutional grants for specialized fields is another instrumentality that should be encouraged in providing support of Government-sponsored research in non-Governmental installations.

(Concluded on page 166)

The Hospitals of Rome in the 1830's

3. The Hospital of S. Giacomo in Augusta

by **REV. ALPHONSE M. SCHWITALLA, S.J., President Emeritus • Catholic Hospital Association**

Early History of San Giacomo

SINCE THERE ARE SEVERAL important churches and institutions named after St. James in Rome, each bears a significative addition to the name of the Saint. But even that is not adequate in all instances to serve as finally definitive. This hospital of St. Giacomo (James) is one of those institutions which has a long pre-history. Attention has already been called to this historical peculiarity, especially in Rome, in the brief sketch of the Hospital Ss. Salvatore.

The Hospital S. Giacomo is commonly (not always) said to have been founded in 1338. There is some evidence that at that date a previously existing, but somewhat dilapidated, institution was first restored before the magnificent new addition, architecturally one of the finest in the city, was erected but apparently the detailed records of such a previous hospital were not available even in 1338. There can be little doubt however, that at least a church or public chapel by the name of S. Giacomo was in existence at the time when the new hospital was erected.

S. Giacomo in Augusta

It is possible that the Church of S. Giacomo (in Augusta) was sometimes confused with the Church of S. Giacomo in Spagnuoli, which was at one time the national church in Rome of the Spaniards, and hence was named after St. James of Compestella. To this church, too, a small hospital for Spaniards was attached (not the hospital of which there is here question). Both the church and the hospital of St. Giacomo Spagnuoli were places of great devotion for St. Ignatius and St. Francis Borgia as well as for St. Charles Borromeo. In 1749 St. Leonard of Port Maurice preached an outdoor mission in the Piazza Novanna in front of that church and hospital which was followed by many miraculous graces.

The history of the church and hospital of S. Giacomo in Augusta has an entirely different pre-history. The suffix to the name of S. Giacomo "in Augusta" refers to the hospital's location in an area of the city commonly named after the Mausoleum of Augustus, which was erected by the first Roman Emperor in the year B.C. 27. Gradually, among the people of the area, off the Corso, it seems to have acquired the "surname" "in Augusta (Regione)." The mausoleum has a most interesting history, having been involved through the subsequent centuries in many military and political events too complex to review here.

The founder of San Giacomo is usually said to have been Giacomo Cardinal Colonna, who is said in some accounts to have had as co-founder his nephew, Pietro Cardinal Colonna. These details may seem very simple and brief but they are really enmessed in countless historical complications. There can be little doubt about the central facts concerning the interest of members of the Colonna family, the hospital builders, nor about major

changes having been made in the year 1338, but it is equally certain that in subsequent centuries the institution repeatedly underwent significant changes in structure, management and policy. The hospital with its church was the center of many distinguished persons, church dignitaries and saints, as already stated. Cardinal Salviati, for example, who was papal nuncio in Paris during the disturbance after the massacre of St. Bartholomew's night and later became a most prominent member of the Roman Curia, undertook major structural changes in 1600, as did also Pius VII in 1815, two centuries later.

The Founders

Cardinal Giacomo Colonna was inspired to found S. Giacomo in Augusta, according to Morichini, "by the unfortunate conditions of those afflicted with ulcers and incurable distempers." He was deeply touched by the protracted sufferings of such patients and by the loathsomeness of their diseases. It is most difficult for us today to appreciate the conditions which must have existed in such times as those in which San Giacomo was founded. It is equally impossible, however, for us to understand the heroism of, for example, such saints as St. Philip Neri, St. Aloysius, St. Ignatius of Loyola, (18 hospitals are mentioned in his life in which at various times he exercised his heroic charity), St. Camillus of Lillis, St. Cajetan (The Theatine), St. Vincent de Paul and numerous others, not to speak of innumerable women saints and others (St. Catherine of Sienna or St. Elizabeth of Hungary) who expended their energies in the same divine self-sacrifice. In the course of time—there is some uncertainty about the date—S. Giacomo was entrusted to the Confraternity Santa Maria del Populo, perhaps at that time the most popular Confraternity in Rome. This Confraternity has a most eventful and interesting history.

Diseases

The confraternity as well as the work of the hospital made a deep appeal to the people of Rome, because from the beginning of the restored institution the hospital gave special attention to severely diseased patients and later, particularly in the sixteenth and subsequent centuries, to syphilitics (so called at that time). Such patients were rigorously separated from other "incurable" patients.

Pius VII (1740-1823; pope, 1800) made important alterations in the structure, but even more important he added to the hospital a "clinico-chirurgical school for both men and women." Just how far flung in influence this addition eventually became can scarcely be stated without considerable research into records, but it must mean at least that ambulatory patients who needed daily care were able to get it at San Giacomo, without entering the hospitals as bed patients.

It was a characteristic of this hospital that segregation of patients by sex and disease was scrupulously observed. The utmost care was used to separate the syphilitics from other patients, even though probably the mode of transmitting the disease was not understood adequately.

Regimen and Personnel

There were two large wards containing respectively 150 and 180 beds. In addition there were a number of pre-operative beds as well as several emergency beds in connection with the outpatient service. Morichini cites the total number of beds as 356.

Except for features which would be specially required for its particular kind of patients, the administration and patient-regimen of San Giacomo conformed in general to those of the other public hospitals of Rome. There was, however, one special feature in the administration. This hospital had its own Board composed of two clergymen—one being of a higher dignity, the other a priest—and a layman. The administrator was also generally a clergyman with the title of "Prior."

Visits by clergymen and lay persons were encouraged and the sisters from the Hospital San Salvatore were given charge of many duties and responsibilities in the female ward and rooms. The professional medical personnel was probably adequate. There were two full-time physicians with two assistant physicians, two surgeons with two deputy-surgeons and 15 students. These persons, with full time administrative and nursing personnel and chaplains—"the hospital family"—numbered 70 individuals.

Census and Support

The seasonal variation in the number of admissions seems to have been marked, but there is no indication that a study of that fact was ever attempted. The months of January, July, August and September, in a 10-year period, showed the highest number of admissions while the deaths were highest in October and November, and 1,625 patients were admitted annually. The State support was supplemented by generous private donations.

Coöperating Institutions

The Hospital S. Giacomo maintained a coöperative relationship with two Roman protective institutions to safeguard the welfare of girls who were discharged as "cured" but who were not in a position to safeguard their own domestic, occupational and spiritual welfare. These two institutions were "The Retreat of the Cross" and the "Asylum della Lauretana."

The first "Ritero della Croce" was founded in 1793 by a distinguished and charitable lady, Maria Teresa Sebastian, for young women who after discharge from San Giacomo were unable to form plans for their subsequent living. Pius VII took a hearty interest in the work of "della Croce" and facilitated the enlargement of the institution in 1804. Twenty girls were accommodated but married women and widows were not admitted. The institution was state-subsidized and had a small endowment of its own.

The other institution, "Refugio della Lauretana," supplemented the work of the Ritero della Croce by taking care of 14 girls, also discharged patients of the Hospital San Giacomo. It owed its existence to a noble lady of the greatest distinction, the Princess Teresa Doria Pamphilia, of the famous noble nautical family of Andrea Doria originally of Genoa. She is said to have taken a deep personal interest in the girls who came to the Refugio della Lauretana. The girls were allowed to come and go freely, subject only to reporting. They were free to accept lucrative employment, subject to a similar condition. Occupational and personal assistance and advice were freely available, as was also an effective placement program.

The arrangements here described afford an early illustration of a successful health and social welfare program, including educational and protective advisory features. ★

NURSING EDUCATION

Conducted by Margaret Foley

A Faculty's Choice:

Education—the Means

Future Service—the Goal

by SISTER ANNE JOACHIM, C.S.J.
Director, St. Mary's School of Nursing
Minneapolis, Minn.

■ THIS IS A THREE ACADEMIC YEAR diploma program in nursing. Full tuition ($2,200), room, board and all other expenses are charged. Students have regular school vacations: three months in the summer, two weeks at Christmas and ten days at Easter. No relief, night, or weekend experience is assigned until the last quarter of the senior year. The student graduates in June of her third year. Faculty members are on 10-month contracts and have regular school vacation periods.

EDUCATION FOR THE ATOMIC age presents a peculiar challenge to a diploma program in nursing. Few educational programs are so little geared to a rapidly changing social and economic situation as is the traditional nursing program.

The School Improvement Program of the National League for Nursing and nursing itself, struggling in various ways for professional recognition, exert an increasing and salutary pressure on nursing education programs. Other professions in the health field and the general public continue to urge nursing to return to the "good old days"—or in some way to improve the quality of its performance. But the dramatic changes at St. Mary's School of Nursing, Minneapolis resulted from internal pressure—dissatisfaction with the traditional program and with the product.

After the eagerness of the freshman student is gone, there is discernible to a perceptive faculty a certain sullen resentment. It is vague usually, diffused, and somehow omnipresent. The "junior slump" is more severe in some classes but in almost all nursing school situations it is marked enough to be harmful. The attitude toward authority and management becomes hostile and goes beyond the point healthy for young adults undergoing the expected pain of growth. To this faculty it seems that the traditional approach in nursing education perhaps necessarily produces these results.

It is, first of all, a false and patronizing approach. "We are giving you this marvelous higher education, the opportunity for wide experience, and the chance to give service which is at the very center of your wish to be a nurse. We are all experts and eager to help you learn." This, in fact, is not true. Generally, diploma programs are not *quality* higher education. The educational experiences consistently run second to the service needs in planning, in practice and in prestige. The opportunities for wide experience and to give service—for which the student, simply because she is a student, is not yet prepared—are questionable. The opportunity, more realistically, is to get the work done, and the eagerness to help the student learn is secondary to caring for the patients. And this is as

it should be, because caring for the patients is the legitimate primary aim of the entire hospital staff. What *is* false is the claim that the student is the first concern of all. Properly, she is the first concern of the faculty. It is equally inappropriate for the faculty to think they are answering the needs of service with the student assignments or that this is a favor of some kind the school is conferring on the hospital.

The authoritarian structure of the hospital organization and the giving of a complete program of education for a nominal sum of money establishes and maintains an undesirable dependency. Nursing faculties profess to teach the student a degree of independence of judgment. The hospital situation, at least under the traditional arrangement, does not really permit this kind of activity on the part of the student.

The student has been given everything by the school or hospital—education, textbooks, meals, room, uniforms, laundry—and sometimes even transportation money. It is not a question of her appreciation of these things. One questions, rather, the harm done to the student's potential for development.

At an earlier stage of development, faculty members of schools of nursing felt a real need to protect the student from exploitation. This protection encouraged dependency and it gave the student a false notion of what was owed to her by the hospital. This reminds one of the domestic servant situation which existed earlier in this country. The servant was in a way so completely a part of the family, and the pay was so grossly inadequate, he felt a kind of right to his master's goods. This sort of relationship the student transfers somehow to all in the hospital.

■ **ST. MARY'S School of Nursing, Minneapolis, was inadvertently omitted from the list *"Accreditation Deferred"* in February HOSPITAL PROGRESS (page 26).**

The school of nursing, despite protests to the contrary, is still thought of as a major source of service and the hospital seems justified in expecting service. It is, after all, the hospital which supports the school. But, while there are advantages to the hospital in having students in the clinical areas, it is fairly clear now that an increase in service is not one of them.

The graduates of our programs, by and large, are not what we really hope they will be, despite the advances which have been made in nursing education. Upon graduation, the student understandably has a different view of her role from that she anticipated when she entered the program. But, instead of a development or clarification of her original idea, it is a change to another. Generally, what she is looking for is an 8:00 a.m. to 4:00 p.m. job, Monday through Friday, with a fairly sizable income. It is entirely to be expected that the nurse be concerned with her working conditions, but her failure and, therefore, the failure of the profession itself to assume the responsibility for the provision of adequate nursing care is deplorable.

The student usually enters the school with a very strong "service drive." At the end of three years, this is fairly well dissipated, or at least it has assumed a secondary importance. She seems to feel she has done her share of weekends, split shifts, relief and night duty; so, as a new graduate she immediately looks to the student to discharge responsibilities which are properly those of the staff and of the nursing profession itself. She is concerned first with her own convenience and secondarily with the needs of the patient. And it is no wonder—she is but a product of her training! It is time for change.

St. Mary's Hospital in Minneapolis has had a program in nursing for over 60 years. The hospital operated its own school until 1942, when the diploma program was placed in a liberal arts college with St. Mary's serving as one clinical unit.

The decision in 1957 to withdraw the diploma program from the college setting provided an opportunity to look critically at the traditional practices in nursing education at the diploma level and take a fresh approach. On July 1, 1958 St. Mary's School of Nursing was established as an independent diploma program in nursing in a hospital setting. Instruction in anatomy, physiology, chemistry and microbiology are purchased from the college, using the college faculty, classrooms and laboratories. All other courses and facilities are at St. Mary's. Because

(Continued on page 180)

Table I. Part-Time Work Plan

	FIRST YEAR	SECOND YEAR	THIRD YEAR
	Maximum	Maximum	Maximum
	Hrs. per wk. Total hrs.	Hrs. per wk. Total hrs.	Hrs. per wk. Total hrs.
Academic period—36 weeks	× 10 hrs. = 360	× 15 hrs. = 540	× 15 hrs. = 540
Vacation:			
Christmas and Easter — 3 weeks	× 40 hrs. = 120	× 40 hrs. = 120	× 40 hrs. = 120
Summer —10 weeks	× 40 hrs. = 400	× 40 hrs. = 400	.....
No work — 3 weeks	.....	.....	.....
52 weeks	880 hrs.	1,060 hrs.	660 hrs.
Hourly rate of pay.....	$1.30	$1.45	$1.60
Maximum earnings.....	$1,155.00	$1,477.00	$1,056.00

Conducted by **Viola Bredenberg**

The Head Nurse is a Manager . . .

of both human and non-human resources

by **ANGELA C. COLETTI**
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THE HEAD NURSE TODAY occupies a key position both in nursing service administration and in relation to patient care. In order to discharge adequately the many responsibilities inherent in the position, the head nurse should become familiar with the process of management and utilize its principles in the administration of the nursing unit. As a manager, the responsibility of getting things done through others should be accepted. The head nurse should be able to plan, direct, organize, coördinate and control the work of the unit. When indicated, new concepts of work planning, staffing patterns and other innovations as advocated by the nursing service director should be introduced to the unit by the head nurse.

Three important managerial functions of the head nurse, apart from the responsibility for patient care are: 1. The Manager as a Leader, 2. Managing Personnel and 3. Managing the Resources within the Unit.

The Manager as a Leader

There is no easy formula spelling out what makes an executive. We do recognize, however, that personal qualities, professional and/or technical competence and practical experience are contributing factors in our concept of what it takes to be a leader:

1. A leader should be an optimistic opportunist, confident of the road ahead and should possess the ability to inspire people to noble efforts.

2. A leader should have the vision, imagination and courage to make needed improvements and demonstrate a sense of priority and ability in things that need to be done.

3. A leader possesses a problem-preventing attitude and frequently employs what Father Keller calls, "a holy habit of anticipating." The anticipation of problems and their aversion by sound planning is also a good mental health principle.

4. A leader possesses the ability to awaken men to the acceptance of personal responsibility.

5. A leader leads, does not drive; uses persuasion rather than force.

6. A leader's personality should be stimulating, dynamic, energetic, enthusiastic and resourceful. These contagious qualities help beget other leaders. They are necessary in a workaday world.

7. A leader should be sensitive to the needs, feelings, attitudes and thoughts of others. She is able to see the wear and tear of grueling emotional situations on the individual and helps by educating, counseling and being interested in their welfare.

8. A leader has the ability to adjust to different types of personalities and has a deep respect for others.

9. A leader takes stock of herself from time to time and is willing to learn from others. She recognizes that all do not have the same talents and abilities.

10. A leader uses good judgment in making decisions, takes a stand on issues, expresses opinions clearly and, if necessary, admits errors.

This list is by no means complete, for it is only a beginning of a long list of assets that help us relate to our fellow beings.

The head nurse should serve as a talent scout and coach those individuals who demonstrate potential abilities—if necessary appoint the person as an "understudy" to work closely with successful leaders who will provide the young talent with every opportunity to develop her capabilities.

The leadership role is manifested in everything a head nurse does in rela-

tion to patient care, the staff, in relation to plans for necessary improvements, relationships with other departments and so on. Leadership implies an understanding of people and the ability to work with them effectively. In order to do this, the head nurse must become a student of human behavior. She must know people, how they act and react, why they act as they do; be able to size them up, their demonstrated and their potential ability; learn how to take orders, give orders; learn to join with other colleagues in common efforts, to motivate people to action that is needed, cooperate with others and be a good follower at times. A leader should be able to communicate ideas to others and receive communication from them. She should not only organize her own activities but those of the group. She will have to work hard at the job, to keep on working and liking it.

Four significant managerial functions that a head nurse should understand and apply in the area of managing personnel are: 1. *Planning the assignment*—in the work situation should be based on a philosophy of respect, dignity and worth of the individual as well as the development of the individual's potential by assisting the worker in the maximum use of his abilities. 2. *Organizing activities*—that will improve ways of working together, developing good morale and an esprit de corps. 3. *Directing the customary patterns*—of work and when change is indicated help to engineer changes through education and good human relations. This approach would help minimize resistance to change. 4. *Coördinating the efforts*—of the staff by frequent and periodic evaluation of progress to date. This evaluation will not only assist the head nurse in her coaching activities but will improve group activities.

We are all aware of the need for more personnel in the health field. As a result there is some experimentation going on in the staffing patterns in nursing situations. It is interesting to note the following concepts, so aptly summarized in the pamphlet "Getting the Work Done With Fewer People": 1. Improve organizations of the work unit, 2. Simplify methods, 3. Increase employe ability to do better work and 4. Increase the employe's will to work.

The head nurse, in supervising the work activities of personnel, must orient the staff as to what is expected of them and then hold them accountable for activity assigned. If necessary, further training may be indicated to stimulate and motivate an individual worker in order to have him bring to the job his creative talents and initiative. Everyone desires to do new things. This principle should be utilized as a basic need in assigning the staff.

In the area of personnel management we are all aware of the need for educational programs, counseling and evaluation as it relates to the preparation of workers to perform in a job situation most effectively. It is possible with a problem-preventing attitude and farsightedness to avoid these situations that hamper progress in a work situation.

Problems that tend to occur in many work situations should be analyzed. They could be minimized through education, counseling and evaluation. Some common problems and possible solutions, are listed below:

1. *Problem of tardiness and absenteeism:* We must have a definite policy to adhere to, particularly in reference to the immature worker. The employe must be informed of the policy, (such as reporting to one's immediate supervisor before resuming work —unnecessary delay in reporting may result in loss of pay) at the time of employment and periodically thereafter. Firmness is essential, as well as the follow-up of repeated offenders. If counseling does not help the worker improve, then severance from employment may be indicated.

2. *Problem of individuals who frequently report injuries on-the-job.* Example—back injuries or accident-prone individuals—those interested in getting the benefits of compensation insurance. A thorough physical examination by the hospital physician may rule out the individual who tends to make excuses to avoid heavy work responsibilities. If a chronic weakness has been identified at the start, the individual may or may not be employed as the case may be. If employed, then a positive program of education in body mechanics, proper lifting and prevention of injuries should be instituted if we are to help the employe. A similar approach may be used for the accident-prone individual.

3. *Problem of employe's negative attitude toward work and/or co-workers.* Improved attitudes may be fostered in good work relations programs, good work conditions and an on-going inservice program. Counseling on an individual basis will help in many instances, if not, a firm policy may have to be enforced.

4. *Problem of rapid turnover of staff, internal mobility, transfers and promotions.* What is the real cause of turnover? Is it known or has a socially acceptable reason been given? Perhaps the real reason has been a mounting wave of dissatisfaction. This contagious element should be stopped very early if it is at all possible. Counseling is effective. Organizational structure may need to be improved if weak; proper preparation for the job is necessary, as well as delegation of responsibility with authority to decide action to be taken. All this will do much for stability. We all need to feel important and useful to an organization.

5. *Problem of prevalence of complaints, grievances and general dissatisfaction.* Good personnel policies, effective planning to meet the needs of the personnel as well as of the service should eliminate such a problem. Early observation of behavioral changes in the worker should be discussed before dissatisfaction sets in. Orientation and continuous educational programs are essential in good personnel management.

The head nurse sets the pace for good interpersonal relations in the unit. She should give out so-called "psychological paychecks" whenever necessary. A coöperative and coördinated staff will bring about needed improvement as it relates to patient care. Skill in the area of human relations can be improved when we understand and respect the individual as a man, an intelligent being and assist him in doing the work he is capable of; challenge him to develop his potential.

The head nurse, in providing an effective work area, contributes immeasurably to the education of the student nurse, the staff and, most important of all, a desirable environment for the care of the patient.

Management of Resources Within the Unit

The essential resources related to the improvement in services rendered may be divided into three categories. They are: 1. physical setup, 2. materials, supplies and equipment and 3. a system of controls; policies, records and routines.

The physical set-up of the hospital,

(Concluded on page 152)

LAW FORUM

Legal Authority in Hospital Management

by **WILLIAM A. REGAN, Attorney at Law • Providence, R. I.**

MANY ADMINISTRATORS of voluntary non-profit hospitals today, particularly those who are not themselves physicians, find themselves in the middle of a controversy over management authority. The principals in this misunderstanding over WHO controls WHAT are generally the chief administrative officer of the hospital and representatives of the medical staff. This is an old problem now manifesting itself in a new and different way. I believe that if it exists at your hospital, it can be solved with all of the cordiality necessary to restore ruffled relationships.

The Problem

The problem, in its legal analysis, looks something like this:

Point of View of Administration

■ CHARGED WITH DAY-TO-DAY management of hospital affairs, the administrator feels the need of almost absolute control over internal and external hospital business. This is understandable in the light of responsibility vested in the chief administrative officer of the average voluntary non-profit hospital today in the United States and Canada. From a legal point of view, there is no doubt about the propriety of the customary practice of hospital trustees who delegate ordinary management responsibilities to some one competent individual. Further, from a legal point of view, it is clear that *this chief administrative officer stands in the place of, and acts with the authority of, the trustees of the hospital corporation.* This gives the administrator the scope and measure of authority necessary to coördinate the various services and departments of the hospital. The legal backing of the trustees is assured as long as the administrator contains his or her actions within the scope of delegated authority. The best evidence of this authority is the usual pertinent provision in the hospital bylaws. The typical clause setting out the delegation of management authority should read something like this:

> The Board of Trustees of ..... Hospital shall appoint a competent, experienced administrator who shall be its direct respresentative in the management of the hospital. This administrator shall be given the necessary authority and held responsible for the administration of the hospital in all its activities and departments, subject only to such policies as may be adopted and such orders as may be issued, by the ..... Hospital Board of Trustees, or by any of its committees to which it has delegated power for such action. This administrator shall be the "duly authorized representative of the Board of Trustees in all matters in which the Board of Trustees has not formerly designated some other person for that specific purpose.

Just as the trustees have the fiduciary obligation to preserve the physical assets of the hospital corporation and carry out the chartered purposes of the corporate enterprise, so also the administrator is charged in a vicarious manner with this same profound legal responsibility.

It would be *wrong* for the chief administrative officer to completely delegate away this fiduciary responsibility to a subordinate officer in the hospital. It would be absolutely *illegal* for an administrator to surrender or abandon this responsibility in the face of pressure from any source within or without the institution. The author's association with hospital adminstrators throughout the United States and Canada assures him that most directors and superintendents in voluntary non-profit hospital corporations are alert to this legal responsibility and discharge their duties accordingly. As a matter of fact, it is ironic, but true, that this keen awareness on the part of many hospital administrators to their basic legal responsibility for management and control seems to unwittingly provoke many of the internal management problems with which we are concerned.

When you stop to realize that for every 100 beds, our hospitals have a gross annual income of about one million dollars, the nature of the administrator's corporate responsibility comes into sharper focus. This person charged with general management responsibility needs all the authority and control that can be mustered.

Point of View of Medicine

■ WHILE THE PATTERNS of patient care have changed radically in recent years, the abiding sense of personal responsibility which the average physician feels for the safety and well-being of his patient has not changed. Let us hope it never does change. We have always been profoundly impressed with this genuine evidence of professional and personal concern for patients which is manifested by exemplary doctors in every specialty and in general practice. Multiply this traditional responsibility which the average doctor displays towards his patient by the number of doctors on the staff of a typical hospital. One can then begin to appreciate some of the apprehension and concern displayed by individual doctors and groups of physicians in the face of any changes or modifications in hospital rules and regulations. In the event of disruption of the status quo, every physician asks himself: "How will this affect me and my patients?" The reluctance of many doctors to accept changes is not as self-serving as it may first appear to be.

One would like to think that the medical staff in the average hospital recognizes the delegation of legal authority from the trustees of the corporation to the chief administrative officer as an orderly and systematic pattern of good business procedure. Assuming that there is this recognition by medicine of the legal authority vested in the administrator, the hospital medical staff should exercise self-government with this administrator's authority in mind. *When the existing medical staff self-government eclipses the authority of the chief administrative officer, the decorum of calm internal management is disturbed;* and the sparks fly fast. Medical staff self-government must never be permitted to assert itself to the point of anarchy. It must not usurp the legal authority properly delegated to the hospital administrator. It is the administrator's task to insure that this sad state of affairs does not occur.

Here, the hackneyed observation is in order that the hospital is no longer (and should never have been) merely "the doctor's workshop." The desirable concept of the hospital as a real medical center is at last coming of age. All of the professional, skilled and semi-skilled services in the modern hospital must be properly blended if the sum total of this marvelous effort is to be realized in good patient care measured by current high standards.

Our traditional democratic processes favor medical staff self-government. Physicians in every hospital have the talent and should be provided with the opportunity to regulate and govern their membership. However, nothing but hard feelings, strained relationships and disorder in hospital management can result when this body of regulations, which governs the activities of the medical staff, makes a mockery of the authority which is legally reserved to the hospital trustees or delegated properly to the chief administrative officer. A typical illustration of the problem under consideration here involves the undelegable duty of the trustees to make medical staff appointments and dismissals. This obligation cannot even be delegated to the administrator. Nevertheless, in more than one instance, the author has seen medical staff bylaws which recite the fact that, following consultation with the administrator, *"the Executive Committee of the Medical Staff shall appoint or reject an applicant for Medical Staff status in the Hospital."* If such a regulation came to pass because of ignorance of the law, the hospital and staff are in need of better legal counsel. If the regulation reflects the fact that the doctors have taken over the control of the hospital, the trustees have been grossly derelict and should be replaced.

A Suggested Solution

■ MANY OF THE RECOMMENDATIONS of the Joint Commission on Accreditation of Hospitals have been helpful in clearing the air regarding the relative responsibilities of the administrator and the medical staff. The recommendation regarding the establishment of a Joint Conference Committee, composed of equal representation from the administration and the medical staff, is an example of such constructive work by the Joint Commission. However, all of these splendid suggestions, whether they emanate from medical or hospital sources, will not insure harmonious internal relations until the legal lines of corporate authority are recognized and adhered to by the administrator and the medical staff.

The problem will not quietly resolve itself as the sands of time flow on. Hospitals which have surmounted difficulties in administrative-medical staff relations and now bask in the sunshine of a well coördinated division of responsibilities have found that this power struggle was resolved only when both sides recognized the legal and professional prerogatives of the other. Any non-medical administrator who presumes to establish policies for hospital medical practice without first obtaining a well qualified medical evaluation and opinion on the matter is heading for trouble; and he deserves it. Can one begin to count the number of administrators accused of exercising medical judgment without having a license to do so?

On the other hand, any doctor who regards himself, or is regarded, as superior in authority to the chief administrative officer of the hospital *has overextended himself legally and professionally.* He is dangerous to his profession, his colleagues and to the hospital. All of the policies, rules and regulations for the government of the medical staff should reflect the proper subordination to the prime authority of the hospital trustees and the vicarious delegated authority of the chief administrative officer. When such order of authority exists, the matter of legal authority in management is crystal clear; and a power struggle is non-existent.

Every set of medical staff bylaws in our voluntary non-profit hospital corporations should contain a clause to the effect that "in the event of conflict in language or understanding between the medical staff bylaws and the rules and regulations for the government of the hospital corporation, such conflict or misunderstanding is to be resolved in favor of the express language in the hospital rules and regulations." This type of clause might be colloquially described as "good preventive legal medicine." It is designed in anticipation of the occasions to be expected when there appears a substantial conflict between the medical staff regulations and the bylaws of the hospital corporation. Such a clause reflects the proper subordination of the medical staff in the over-all pattern of corporate legal responsibility in patient care. At the same time, the right of the medical staff as an intelligent and responsible group to carry out its assigned duties in the hospital *within the pattern of self-government* is adequately preserved. ★

St. Expeditus Hospital

Dear Sister Michaeleen:

Life with the Liturgy of the Church is moving along gracefully at good old St. Expeditus. The nuns and nurses get a break during Lent, since I am participating in the local exchange of pulpits during the holy season and Father Harry Schultz is giving the Wednesday night sermons at the hospital. I get a break, too. I have the series on the Sacraments over at St. Margaret of Scotland and I generally arrive there before the evening meal. They have a good housekeeper and—while the Sisters' chaplain is supposed to be among the three best-fed beings in the world—a change now and then is good for all.

Sister Dymphna reminded me the other day to thank you again for your interesting notes on nursing care plans for psychiatric patients. She had a great deal of it already incorporated in her unit, but she particularly appreciated some of your fine points. Graduate school really put you on the ball. Sister D. and I had a long talk about the nursing care plans. Since I am on the state board of the League for Nursing, I have to make an effort to keep interested in associated fields. Some of the nursing care plans seem to be quite simple—just a matter of listing the challenges and the approaches, although actually I don't suppose even getting an accurate list of both would be really easy. Other situations I've observed seem to indicate that perhaps the doctor or the psychologist really aren't on the therapeutic team, except for the drastic therapies and the tests.

I received the impression sometimes that nurses were doing the nursing and nobody was going to tell them what the patient needed in their area. On the other hand, a lot of us have been impressed with the way Sister Dymphna handles her nursing care programs. They call for a listing of all needs of the patient, for developing three needs thoroughly—specific actions of the nursing student, reaction of the patient, feelings experienced by the nurses—and a check on what members of the nursing team are doing to motivate the group toward the identified nursing aims for the group. As one of our patients told me the other day: "They're really trying to help you here."

The big thing here at St. Expeditus are our five S's—short, simple, strong, sincere and saintly, particularly in regard to communications with the public or the patient—and even the padre.

Some people can really complicate things. For instance, take this quote I saw the other day: "While the physiologic decrements and true organic deterioration are largely irreversible, well-motivated workers know that psychologic factors are amenable to appropriate therapy in a well-integrated milieu." That's like using "lacerations and contusions" to describe "cuts and bruises."

Whispering a subdued "Alleluia," I remain in the one loving Christ Himself,

Father Brian

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CLINICAL LAB

The Spirit of a Teaching Program

(Part One)

by **REV. JOHN L. THOMAS, S.J., Assistant Professor, Department of Sociology • St. Louis University**

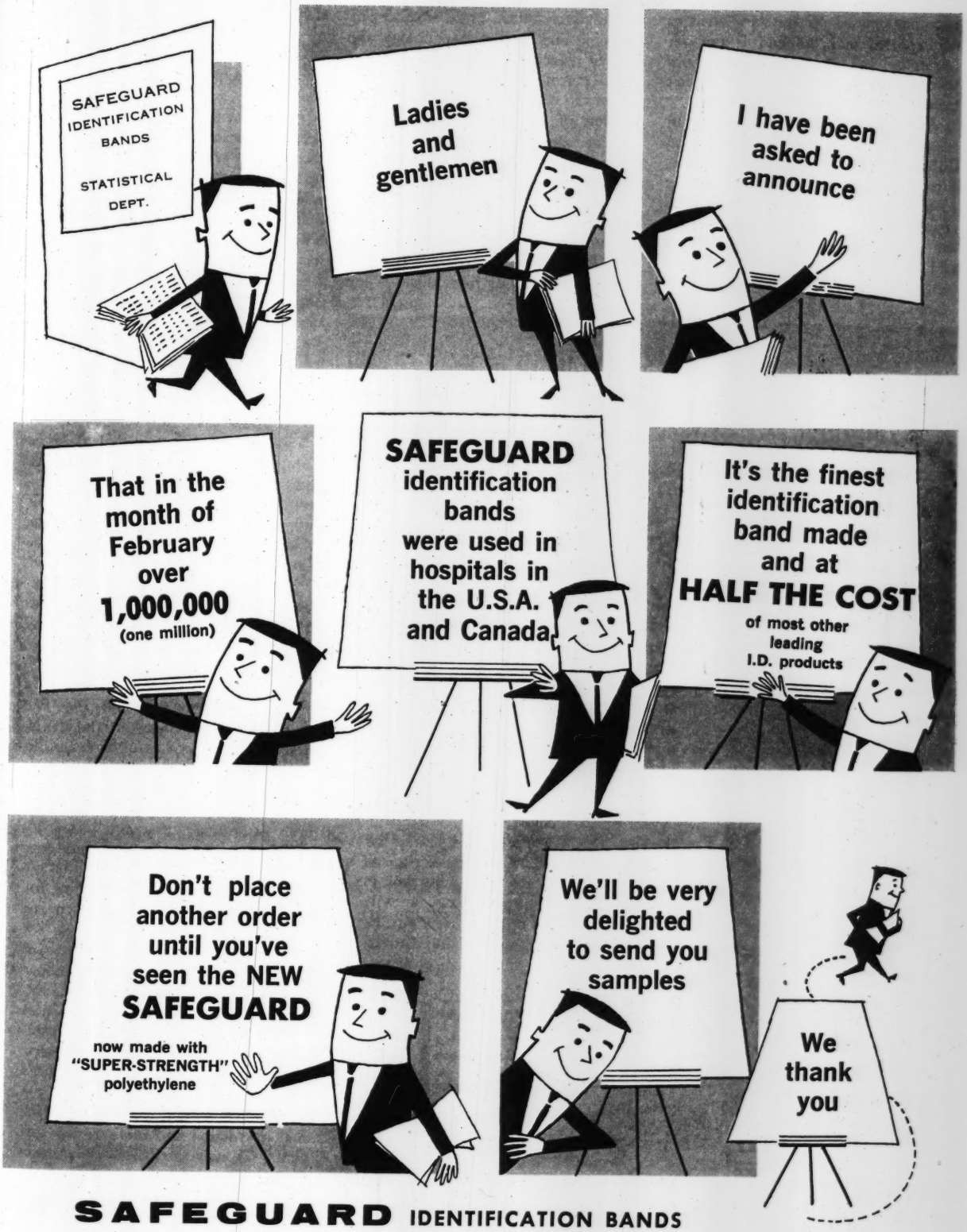
THE SPIRIT of a teaching program is necessarily affected by the self-image held by the teacher. The status of the professional educator in any society is not without its latent contradictions and ambiguities. The true educator is the guardian, promoter and transmitter of the cultural heritage, particularly in his field of specialization. To the educator, society confides its most precious possession—its youth, trusting that the dedicated teacher will conscientiously mold the rising generation according to the ideals and standards cherished by the nation. Society attaches considerable prestige to this lofty vocation, for the educator is recognized as one who deals with the development of persons, not of things.

On the other hand, the educator is looked upon as a servant of society. Particularly in a social system characterized by an ever increasing division of labor, consequent specialization and the ideal of "rational" efficiency, the teacher is confronted with the unenviable task of focusing education primarily on the promotion of segmented, narrowly specific areas of knowledge and skills rather than on the development of balanced, well-informed, culturally integrated personalities. Because the demand for specialized training has become so great in our society, the lofty role of the teacher runs the risk of being reduced to a mere mechanical job calling for a specified number of working hours to be contributed to an occupation for which remuneration is due. Under the circumstances, there is serious danger that the educator will lose some of his idealism, will accept the public estimate that his work is just another job to be performed, and will forget that he has been attracted to the teaching profession by his desire to promote knowledge and to develop men.

This danger has been a perennial threat to the teaching profession, as we can learn from the trials of Socrates, but modern conditions have clearly served to accentuate it. The educator, by the very nature of the function that he performs, must be endowed with lofty ideals and deep faith. With lofty ideals because in no other way can he motivate and inspire year after year the young students confided to his care; with deep faith because the educator, since he is forming men, will have to wait for years to see the results of his efforts. To be sure, teachers can measure some tangible aspects of their success by giving examinations at the end of the course, but especially educators engaged in training for the professions must wait until their students have had an opportunity to meet the challenge of performance in real life before they can gage the results of their efforts.

Hence the teacher must constantly renew his convictions in the importance of the function that he has chosen to perform. Teaching rises above mere patient drudgery only to the extent that the teacher strives to develop the personalities of his students and to mold them according to the ideals of their profession.

Before discussing the pertinent elements in the spirit of a teaching program, it may be helpful to offer several preliminary observations concerning the wider social context within which medical technology has evolved. In the first place, the widespread application of science and technology in social systems, institutions and professions necessarily leads to an ever increasing division of labor, with the consequent demand for greater specialization in preparation and training. Within the professions, in particular, the speed, degree and extent of change will depend greatly upon how closely a given profession is related to science and technology, as one can see, for example, from a comparison of developments in professions like law and medicine. The amazing advances in health care during the past few decades remain without parallel in human history. It was only a century ago that the remarkable Miss Nightingale waged her heroic battle against the thoughtless barbarity to which the sick and wounded British soldiery were routinely exposed, yet her common sense formula of fresh air, sunshine, cleanliness and kindness



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appears primitive today. Modern science has opened up vast new areas to be explored and the end is not yet in sight. Indeed, as one cynic observed, "We've got drugs we haven't even found diseases for yet!"

Associated with these advances in medical science are the expansion and diffusion of health care services throughout the nation. This trend is so significant because in making the results of these advances available to the general populace, the professions and institutions engaged in furnishing health care services have been forced to expand rapidly while becoming increasingly complex. Thus, advances in medicine and medical technology are quickly reflected in additional services and departments in the hospital; the size of the health team is enlarged; the division of labor is further accentuated; and there is an increased demand for specialized training at both the technical and supervisory levels.

More important, it is the organization, the total health team, rather than the individual which furnishes health care. Even doctors can no longer function productively as individuals—they need the team. Though this dependency may have caused doctors some loss of prestige, it has also generated a vigorous drive toward professional status on the part of other members of the team.

At present the practitioners of many occupations are attempting to achieve recognition as professionals. Services formerly carried out by amateurs are now performed by specialists who normally work in large organizations. This trend is so marked in the field of health care because the various services now available can be administered only by persons possessing considerable knowledge and technical training. Inasmuch as the term *professional* is ordinarily applied to all occupations requiring a substantial intellectual training, a skill in research or practice, and a sense of social responsibility acknowledged by the specialists as a group and expected of them by the public, there seems to be no good reason why the members of the various occupational categories comprising the modern health team should not strive for recognition as professionals.

The process by which new professions gradually receive full professional status constitutes an interesting and instructive social phenomenon. Since most new professions result from a more refined division of labor in a large institutional setting, the first problem they encounter is the definition of their specific function as distinguished from other coöperating occupational groups. Once the scope and dimensions of their function have been determined, adequate means for recruiting and training aspirants must be developed. As a rule, initial attempts to establish formal training follow a strictly vocational pattern and are conducted in a non-academic setting. As the trend toward professional status continues, the training becomes more intensive and extensive, prerequisites are multiplied, and affiliation with traditional academic institutions usually follows. At this point, preparation tends to become standardized, while learning through doing or participation gradually gives way to formal instruction and more or less artificially contrived clinical experiences.

Once an occupation has reached this stage of development, it is well on its way toward the achievement of full professional status. The final step consists in controlling access to the profession through appropriate licensing procedures, since only if member-

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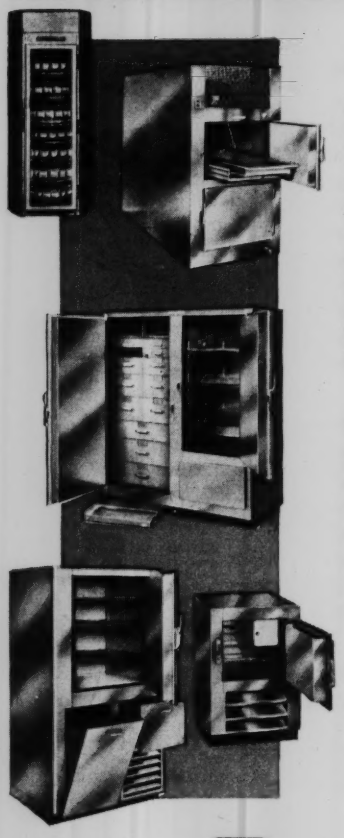

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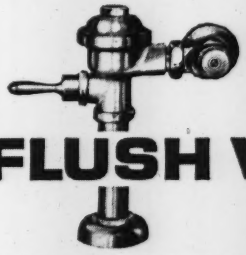

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ship is subject to adequate quality controls can a profession assume full responsibility for the fulfillment of the occupational roles it has defined as its own.

Both during the movement toward professional status and once it has been achieved, the question that remains to plague leadership is, What are we training for? An adequate answer is not necessarily found in the stated objectives, for it is concerning these very objectives that the question is asked. All formal educators must face up to this enduring problem conscientiously, though there is a strong tendency for teachers of the older professions to protect their traditional preparatory system as a vested interest, while curriculum builders of the new professions frequently try to gain prestige for these occupations by merely lengthening or intensifying formal training in the specifically technical aspects of their functions.

Because practitioners of medical technology are now striving to achieve full professional status, the preparation required of candidates must be carefully formulated. A profession, by definition, assumes independent trusteeship of the specific functions or occupational roles it claims as its own, so that society can justly demand that candidates acquire the best knowledge and technical skill currently available. But knowledge and skill are not enough. Professional persons must also possess a sense of social responsibility both for the development of their profession and for the services they render to their clients. At the same time, training programs must provide for the spiritual, intellectual, emotional and social growth of candidates, for specialists are persons. This latter consideration should not be regarded as incidental or secondary in the training process, since professional competency may be separated from responsibility, and a sense of responsibility is rooted in a mature, balanced personality.

Hence in discussing the spirit that should animate your teaching program, the most useful approach may be to consider the philosophy and objectives you should keep in mind when carrying out your work. As followers of Christ, you naturally desire to train Christian specialists, but unless the relationships between religion and professional training are made explicit, there is danger that the students' religion will be relegated to a set of segmented practices only superficially related to their professional life.

We may express the basis for the relationship between religion and the professions briefly by stating that in addition to the formally prescribed and proscribed activities associated with creed and cult, each religious system profoundly affects ethical goals and practices by defining the conception of man held by the group. In supplying the essential elements of our definition of the origin, nature and destiny of man, religion furnishes the indispensable ideological foundation for the system of ultimate goals and premises of values forming the core of our ethical system. This is by way of saying that men develop their definitions of what is right or wrong in the practical order within a broader framework of value referents, organized into fairly consistent schemes or general patterns, and related to their conception of the nature of man and of the world in which he lives. Since religion defines more or less clearly the status or position of man in the cosmic order, it necessarily affects the ethical judgments of its adherents.

(Concluded next month)

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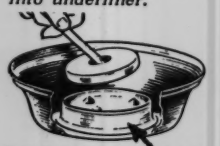

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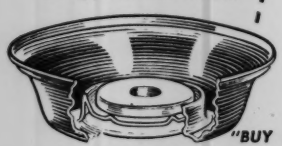

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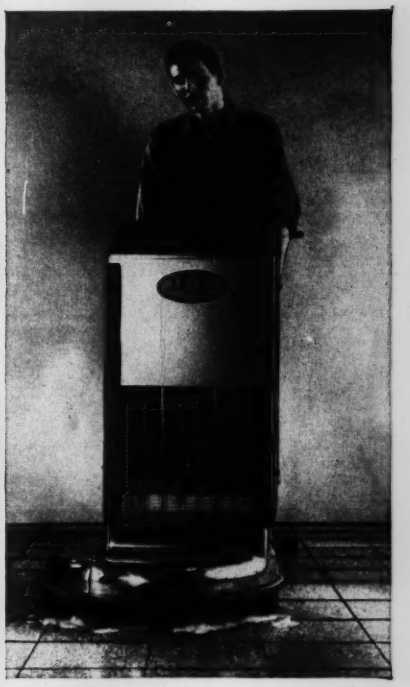

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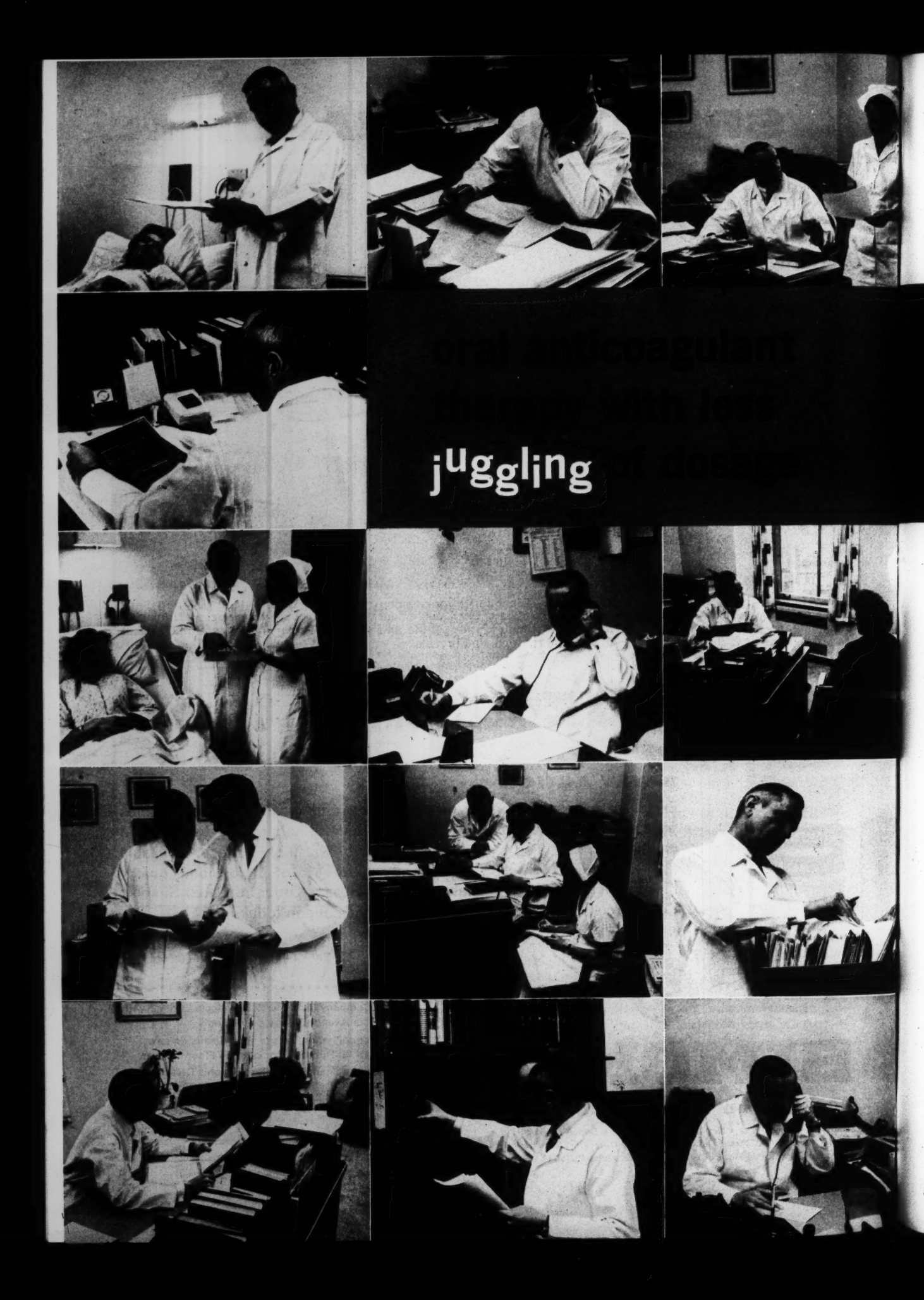
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Mission Hospital Libraries Need Help

by SISTER MARY NATHANIEL, S.C.M.M.*

WHEN PATIENTS BEG nurses for "something to read" and the sister-nurse comes to the convent bookshelves searching for something appropriate—but anyway *something* to give the patients—we wish that hospital library friends knew about our need.

This situation prevailed in a small village hospital in South India; neither that village nor the neighboring ones had a public library. The nearest facility was in a town 24 overland miles away. To reach it necessitated crossing a river by vanchi (45 minutes if the tide and winds were favorable). It was not a lending, but a reference library in a girls' college. The article, however, concerns identical hospital library needs of many other institutions in India, Pakistan, Africa and similar mission areas.

Let us consider first the categories of individuals in a mission hospital who benefit from library service and in what way they benefit. There are: (1) students—in many hospitals; (2) staff personnel; (3) patients; (4) sisters, and (5) ambitious young people of the area.

The *students* may be pursuing studies in nursing, midwifery, dietetics, x-rays, etc., and their medium is English, although they probably converse in and write two other languages or dialects. When their classes and duties are finished, they enjoy reading for relaxation, if they can find something simple and interesting.

This also applies to the *staff personnel*—male and female—who are a little older and have completed their training. They are really eager to read the subject matter written in English and not found in the vernaculars, in order to continue their familiarity with the language and enrich their vocabularies, to enable them to converse with doctors relative to hospital matters and, when necessary, to interpret. Their interest is genuine because they ask for duplicate copies and for old issues of periodicals. Almost none of these are wasted for they are passed from one reader to another until there isn't much left of the original.

The *patients* are next for consideration. It's strange that people who may not read much when they're up and about feel the need for it when they are confined to bed, and what a good thing it is! In many hospitals patients are given the local newspaper, but they want more. There are generally two classes to be considered—those who can read only in the vernacular and those who have had more privileges, more education, who are perhaps in business or professional life and request English reading matter. Some books are available in the vernacular and are extremely popular where they have been utilized. They are inexpensive editions and the Sisters are sure of their having a good influence morally and socially, because they are selected by the chaplains.

As for the few patients who read English, they have private or semi-private rooms and usually enjoy current magazines, illustrated in color. They also enjoy light historical novels and biographies if their stay is long enough. It is hoped that the small patient libraries in a few hospitals may be enlarged and that many other hospitals may encourage the practice of good reading by introducing libraries.

Children. Many patients are "little ones" and aren't children alike everywhere? Some I know are delighted to play with empty spools (from thread or adhesive tape) and empty powder tins. They tie a piece of string to the spools and, if ambulatory, parade up and down the veranda, serenely contented for hours on end. But one sister started to cut up old magazines and paste colored pictures from the advertisements into well-bound, discarded books. She spent all her free moments cutting, arranging, pasting and weighting her "Picture Books." The children in the wards thereafter gave her no peace. They love those books and wish to be shown through them several times a day. Once a sister-doctor made the mistake of giving one to a little

*Sister M. Nathaniel, previous to her entrance into the Medical Mission Sisters, was a teacher in the public schools of Boston, Mass. Since then, she spent two years in London, England, doing publicity at the Medical Mission House, Osterly and four years in a mission hospital in India. On October 26, 1959 she returned to the United States and expects to return to India.

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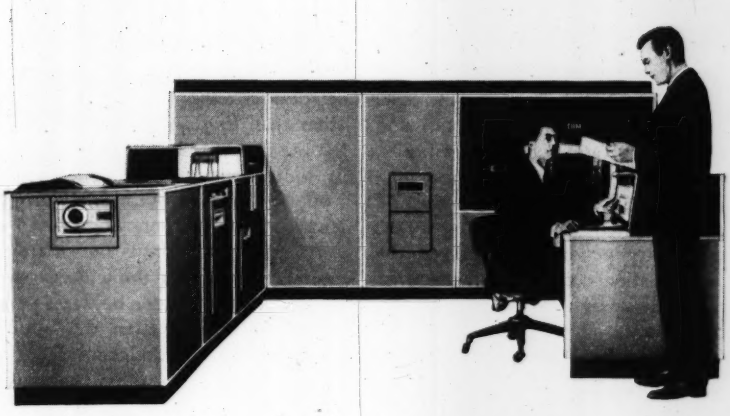

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13. *Program Exit Overlap*—a timesaving device which eliminates, or overlaps in certain cases, the 20-millisecond delay time normally required for excursion to the control panel for logical decisions and branching.

14. *Increased Processing Speed*—reduces the time required to transfer data between the drum tracks, thus reducing over-all operating time wherever process time is greater than input-output time. Reductions of up to 25% in processing time and up to an average of 20% increase in through-put time may be realized with no change in the existing program itself.

girl to peruse, when she went home, she insisted on taking it because, she said, "Sister gave it to *me.*" Many beg to take them home, but this would be futile. Even under the supervision of the hospital staff, some pages are missing, here and there, to say nothing of two of the precious *books.* In the first books Sister pasted lots of automobiles, beautiful scenes, animals, home and the like, but she noticed the children especially enjoyed pictures of *food,* so her later books have plenty of pictures of fruit, candy, baked beans, spaghetti and biscuits.

Paint or coloring books are popular. The Catholic Daily in one mission produces a Children's Edition each quarter. It's a small size, has pictures, songs and children's stories (in the vernacular). There were so few copies in the hospital, approximately six, that they had to be kept in the convent and given out under supervision—and were reluctantly returned.

Game and puzzle books and well-written booklets on miscellaneous topics of interest please the older children. During the Lourdes Year, a little 5″ x 7″ booklet on St. Bernadette reached a mission hospital. It contained no more than 12 pages in all, several of them full-page color pictures. The print was large and the story true. When the local girls first looked at it, everyone sighed, "Aren't there any more?" Then the borrowing started. "Can I please take the book on Lourdes or on St. Bernadette?" After a while we gave it to a younger girl in the area and she radiated her happiness. She was allowed to *keep* this lovely little booklet which appealed to the students and which the Sisters, too, enjoyed vicariously.

The *Sisters* not only benefit from a hospital library, but often depend very much on it for professional reference. They have been well trained and registered but, unless someone at home has a real interest in them and perseveres in "keeping the Sisters up to date," they may find themselves falling behind in current practice and technique. They are, moreover, frequently responsible for training young girls of the area and are eager to follow modern methods, not only for their sake, but in order that their work and that of the staff may assure the hospital a good reputation and give honor and glory to God.

Finally, there is a class of people who might be overlooked—the *ambitious young people* in the area. They are not connected with the hospital, but instinctively respect the "European or American Sisters." They often come asking for "anything to read in English." The age of the book or paper doesn't matter; they simply want the experience of reading and of thinking about what is written in other lands.

How These Needs May Be Satisfied

These needs can be satisfied by the coöperation of interested people who care to contact Mission Societies and ascertain how and where, specifically, they can help best. When a new mission is opened, for instance, one would not immediately wish to set up a hospital library pending analysis of the type of patients and investigation of their reading skill, interests, medium, etc.

At the outset, the professional division of the library may be fairly good *if* the sisters are recent graduates and have brought their current textbooks along, but inquiry could also be made about this and plans laid for supplying revised editions when significant changes are made in any branch (surgery, pharmacy, laboratory, x-ray, dietetics, obstetrics, etc.) or for mailing pamphlets and brochures on research and experimentation in these medical and allied fields.

But, at the very outset, (although it is not the precise subject of this paper) the convent library could be stocked. The sisters, through their provincial or regional houses, would be able to indicate the titles and authors if one individual or group wished to supply the sisters with either books or donations for designated titles.

There are many factors which favor developing hospital libraries in the missions: counteracting the influence of harmful literature; building morale; promoting greater understanding among people; stirring up the imagination or inventiveness of the young and providing worthwhile recreation. When constructive ideas are absorbed through reading, patients are prevented from worrying about themselves and the hospital in general, and from idle gossiping or criticism.

Books are often available in the mission countries (and in the vernacular must be obtained there) so a donation for this purpose is a real help to the superintendent or administrator of a mission hospital. Ordinarily, books are on the duty-free list for imports in mission countries. There are, however, a few cautions that should be observed.

First of all, it is important to get in contact with a particular mission (through houses of the community in the United States). The sisters are in the best position to explain what they can use profitably, what they desperately need and in what quantity. Then, the generosity and efforts of hospital library associations will not be ill spent or wasted.

Unless specifically requested, books or periodicals written in languages other than English should not be sent, for mission countries are already rich in indigenous tongues. Few, if any, would be familiar with any European languages other than English.

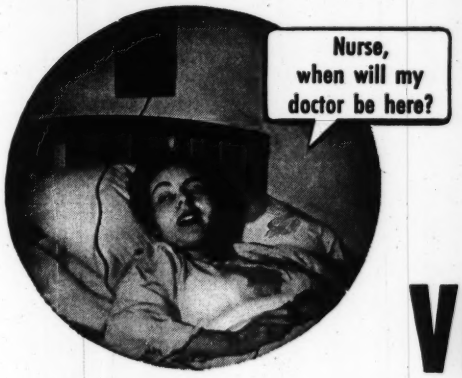
As a rule, humorous books are not desirable because of the wide variation in the sense of humor between people of different areas. Often, the "strange" humor is neither understood nor appreciated. On the other hand, very serious subject matter should be ruled out, since most books sent to mission hospital libraries are destined for the use of the sick. Paperback editions of good books are fine if the print and paper are not of inferior quality. Duplicate copies may be sent, for there is rapid deterioration from both climate and use: Re: textbooks, *only current* ones should be provided. Obsolete textbooks are ineffectual.

Once again, books in good-sized print and with good quality paper, well-illustrated with fine arrangement and absorbing subject matter will help the type of reader found in the mission hospitals.

There is also a responsibility to send only books endorsing high moral principles, that avoid vulgarity and any prejudices that might offend the highly developed sense of tolerance of people in mission lands.

The missions really need the support of library organizations. Catholic hospitals can, with proper coördination of the program, offer this support to the missions—and bring intellectual, moral, spiritual and physical benefit to mission hospital patients. A list of specific suggestions follows:

1. *Good plays are most welcome*—one-act plays and longer ones, also. Certain radio and TV dramas on elevating topics are compiled for broadcast or telecast presentation and later published. They are very easy to adapt for stage performance in the missions.
2. *A limited number of inexpensive*



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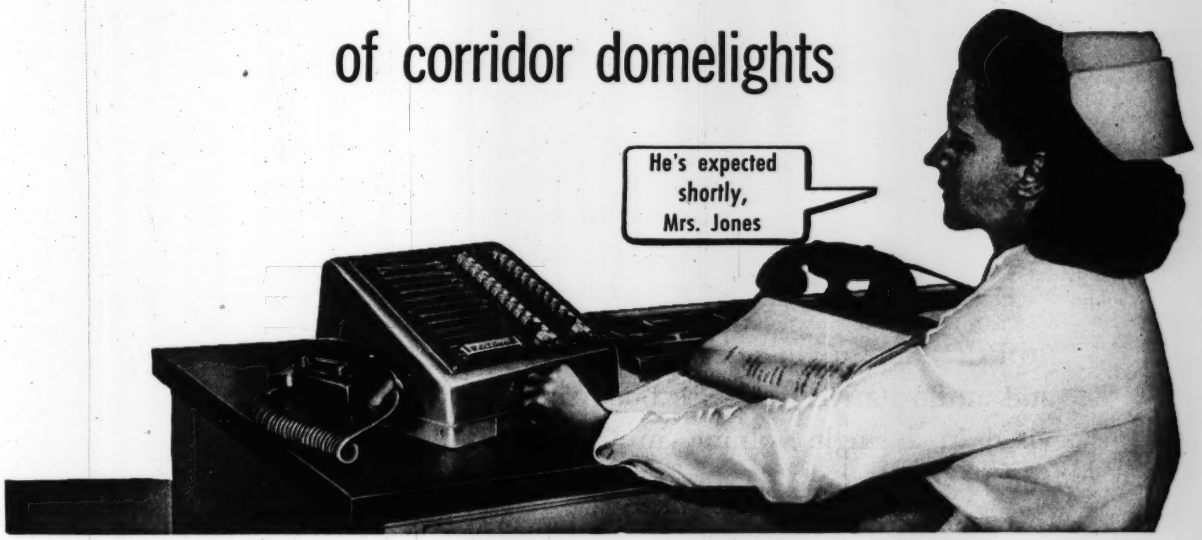

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song books (with notes) are invaluable for recreation. In many missions, the people take to American melodies quite easily (Stephen Foster type, for example) and what a surprise it was to find that one of the 14 official Indian tongues had a song that follows *Clementine* almost exactly! *Alouette* proved *the* favorite for group singing.

3. *Standard reference books:* encyclopedias, World Almanac, atlases and a thesaurus.
4. *Dictionaries* (including medical dictionaries). If these are generously illustrated, they are doubly precious because they save searching for illustrations, clipping and filing them.
5. *Pamphlets,* e.g. those on current topics.
6. *Standard textbooks,* in chemistry, physics, biology, biochemistry, psychology, bookkeeping, hygiene, public health and sanitation. However, these should be recent editions.
7. *Classics,* e.g. Shakespeare's plays, etc. in good editions.
8. *Story books:* simple ones, e.g. *Captain January, Sara Crewe* and *Ruthie.*
9. *Biography.* "The Vision Series," which promotes stories of saints and heroes, are in good-sized type, on good quality paper and sufficiently well illustrated to capture the interest of beginners in this field. More difficult ones, especially new ones, are also solicited.
10. *Travel*—pictorial works preferred.
11. *Mystery stories.*
12. *Collections of good short stories.*
13. *Books on nature:* animals, birds, trees, flowers, gardening and pertaining to the country concerned.
14. *How to Make Things:* stuffed animals for toys, embroidery designs, stamp collecting and other hobbies.
15. *How to Help the Dying,* or similar publications.
16. *Subscriptions* to, or old copies of, periodicals:
    For the convent library:
    World Mission
    Cross and Crown
    Life of the Spirit
    For the "circulating" or "patients" division of hospital library:
    Holiday
    McCalls
    National Geographic
    For the "professional" division of the hospital library:
    Journals of medicine, surgery, nursing, etc.
17. *Literature from societies* concerned with the offering of suffering for supernatural purposes.
18. *Religious:* The Holy Bible and *The Imitation of Christ.*

It must be remembered that this article concerns mission hospital libraries in general, therefore, the suggestions are also general. It is always the best policy to get in contact with the mission hospital one proposes to assist and, through mutual correspondence, determine the appropriate library contributions to be made. Others who are more familiar with what is being done in the library world today will have more fruitful ideas and suggestions. Assuredly the need is there: it is a great opportunity for a real live apostolate. In addition to the obvious results, the missionaries themselves will be strengthened and encouraged by the contact with, and the interest of, the members of Christ's Mystical Body at home who are spreading the apostolate of good reading. ★

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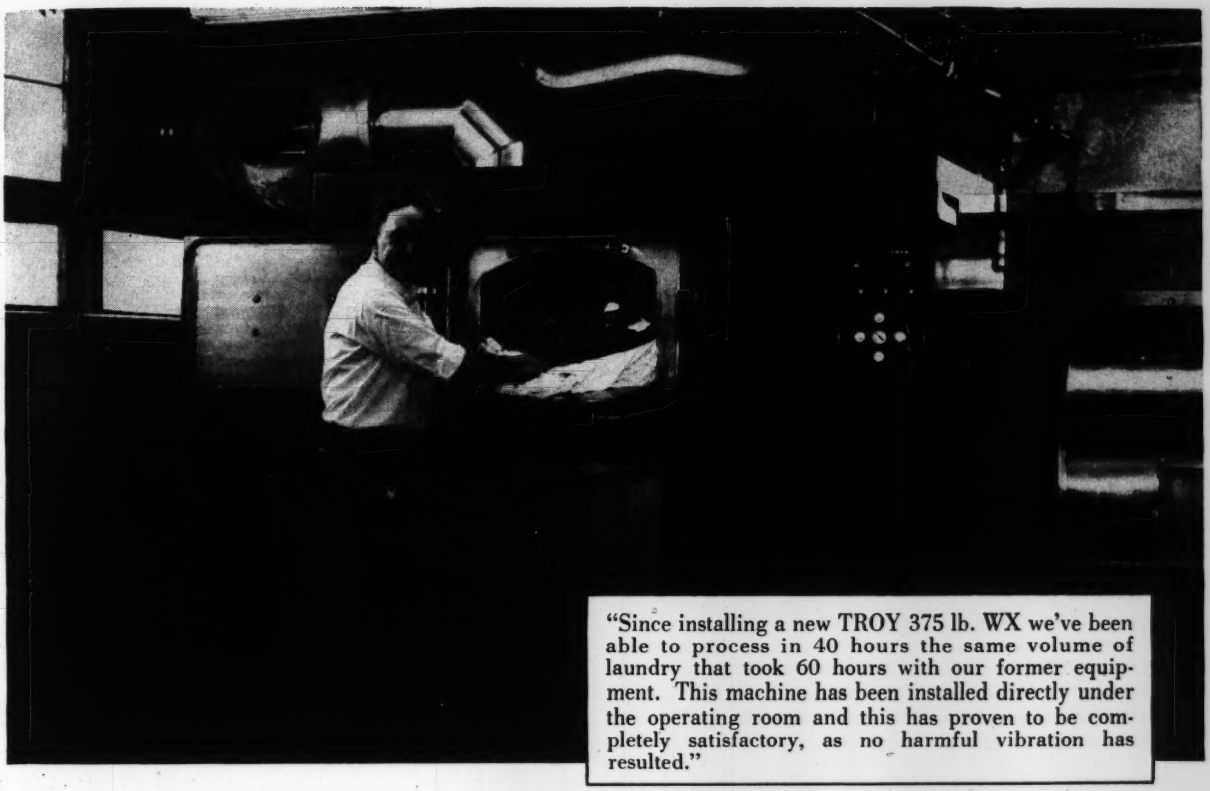

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Preventive Maintenance

by ANNE VESTAL

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University of Florida
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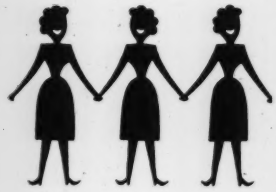

■ PREVENTIVE MAINTENANCE is an important sounding phrase. Administrators cry for it; hospital engineers are always in the throes of *preparing* a program for it. Everyone looks to the executive housekeeper to play a leading part in the implementation of the program when and *if* it is promulgated.

A discreet question—"What is preventive maintenance?"—may bring a look of annoyance and the answer, "why everyone knows what it is; we just want something done about it." Housekeepers murmur "amen" to the latter, and go on seeking the answer. Housekeepers, after all, are the ones who must face daily the problems arising from the *lack* of preventive maintenance. Not the least of these problems is the criticism of our cleaning program. Investigation often proves we have a *clean* house, which *looks* ill-kept because of poor maintenance. A room may be fresh and clean, but *looks* untidy because paint is chipped off the walls; doors are scarred; door knobs are unmatched and there are cracked baseboards and torn tapes on the venetian blinds etc.

Let us go back and *get an answer* to our question, "What *is* preventive maintenance?" The author's answer is dual in nature: The first part of the answer might involve checking the architect at his drawing board and the purchasing agent at his desk; for preventive maintenance is *eliminating*, insofar as is possible, in the physical plant and its furnishings, those items which *create* a need for maintenance.

The second part of the answer lies in the *operation of a planned program of regularly scheduled inspection* of the entire physical plant and its furnishings. This involves *follow-through and immediate correction* of all unsatisfactory conditions, thereby *preventing* the necessity for *major, costly* refinishing, replacement or reconstruction.

At this point, it might prove profitable to direct a series of questions to hospital administrators. An administrator will either have carefully selected a chief engineer or retained the services of one he inherited from a previous administrator. Has he been consulted on preventive maintenance? Has he been asked for a *written program* relative to walls, ceilings, floors, doors, lights, vents, grills, windows; electrical, heating and refrigeration systems; fixed and portable equipment furnishings of offices, clinics, waiting rooms, lobbies locker rooms, patients' rooms, operating suite, delivery suite, x-ray, laboratories, physio-therapy area, pharmacy? If he had no such program to present, was he given a due date for such presentation? Does he have the help needed to get it done? If the program was written, did he have the personnel to activate the program? Does he have an operating budget adequate to provide stocks of parts, motors, points, tools, to make the program effective? Were meetings held with department heads, explaining the program and their part in making it work: due care in use of physical plant and furnishings, thoughtful selection of new equipment and furnishings, immediate reporting of damage?

The following questions might well be addressed to the head of the hospital engineering and maintenance department: Do you enjoy being routed out of bed once or twice a week? Are you tired of being harassed by importuning department heads? Aren't your men justified in grumbling at interruptions of their off-duty time, and at overtime, due to the need for constant emergency repairs? *Now* is the hour to stop all that! Plan not just one day's work at a time, but a reasoned and reasonable schedule of preventive maintenance by month and season, by area, by item. An excuse of "lack of time" is not valid.

Where are you going to get the help? When you get organized, you may find you really have more *productive* man-hours available than ever without increasing your staff. And if you do need more men, can *prove* you need more help, no good administrator will long hold out against convincing facts and figures.

The architect, dreaming big dreams over his drawing board might stop and think a bit: is it really necessary to specify so many kinds of floors and walls, such diverse fixtures, so fanciful a lot of tones, shades and tints? Once this house of mercy is built, who is to maintain it? And at what cost? Construction is paid for only once, but the cost of maintenance goes on forever.

Those wide expanses of fixed glass could be replaced with windows that swivel or reverse, couldn't they? Those soft composition acoustic tiles that break off, even with gentle handling, could probably have been metal pan which is easy to put up, does not break when taken down and is easy to repaint without loss of acoustics. Must prime space be wasted on huge lobbies and waiting rooms, necessitating a reduction in the size of patients' rooms?

(Concluded on page 128)

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RUSSWIN

(Begins on page 122)

What happens to the walls and furnishings in patients' rooms when a complete moving job is necessary to introduce a stretcher into the room? Maintenance, preventive maintenance, *begins* with the architect.

Give a board, give an administrator, a building that is easy to work in and to maintain in working order. They will be less concerned about the size of an architect's fee if he does this. They can, however, become rather quickly disenchanted with the number of special effects which have been created, special designs that were ordered, special fixtures which were specified, especially if these will require maintenance.

The best ally a purchasing agent can have is the housekeeper. She will be glad to work with him BEFORE he places orders for public area furnishings. She can help him avoid the purchase of furniture so unwieldy it's no wonder the men drop it and crack the legs (maintenance). Some coverings do not lend themselves to the daily soap and water cleaning and soon need recovering (maintenance). The housekeeper can tell the P.A. "Sir, here is an overbed table with 21 seams to be kept dirt-free, while here is another with many less dirt-catchers." This too is preventive maintenance.

That towel rack on the back of the dresser will injure walls; why not get one with a side rack which is easier for patients to reach, and no hazard to walls? Check to make sure all mobile equipment is bumpered. Those flat-top lockers won't do at all; they encourage folks to use the tops as waste containers—and our cleaning and pest control problems will multiply.

Responsibility Is Shared

Preventive maintenance depends in a large measure on what the purchasing agent buys. Maintenance can be reduced by judicious selection and purchase. The true price of an item may not always be the one quoted by the factory. The hospital engineer and housekeeper can often estimate the true figure out of the depths of painful experience.

The executive housekeeper has not been charged thus far, in this bill of particulars. Does she work with her engineer in making up room lists and equipment lists? Does she keep him informed of additions and deletions of furnishings from various areas? Does she consult with him relative to proper shelving, risers, racks and bins for storage areas? (Preventive maintenance should take place in the seldom-seen storage spaces too!)

Does the housekeeper train her employes to use their equipment without damage to it or the property on which they use it or move it? Does she train her employes *to see when they look:* to *see* loose chair seats or wobbly legs, loose door knobs, broken windows, scraped doors and chipped walls, scorch marks around light switches, torn tapes —and REPORT AT ONCE what they see?

The housekeeper in turn, reports to the maintenance department for IMMEDIATE CORRECTION the minor, but potentially major conditions. Periodic check-up is her lot, her job. Unremitting vigilance is a small price to pay for the joy of having a well maintained hospital, one in which ongoing preventive maintenance obviates irritating, costly, MAJOR corrective maintenance. ★

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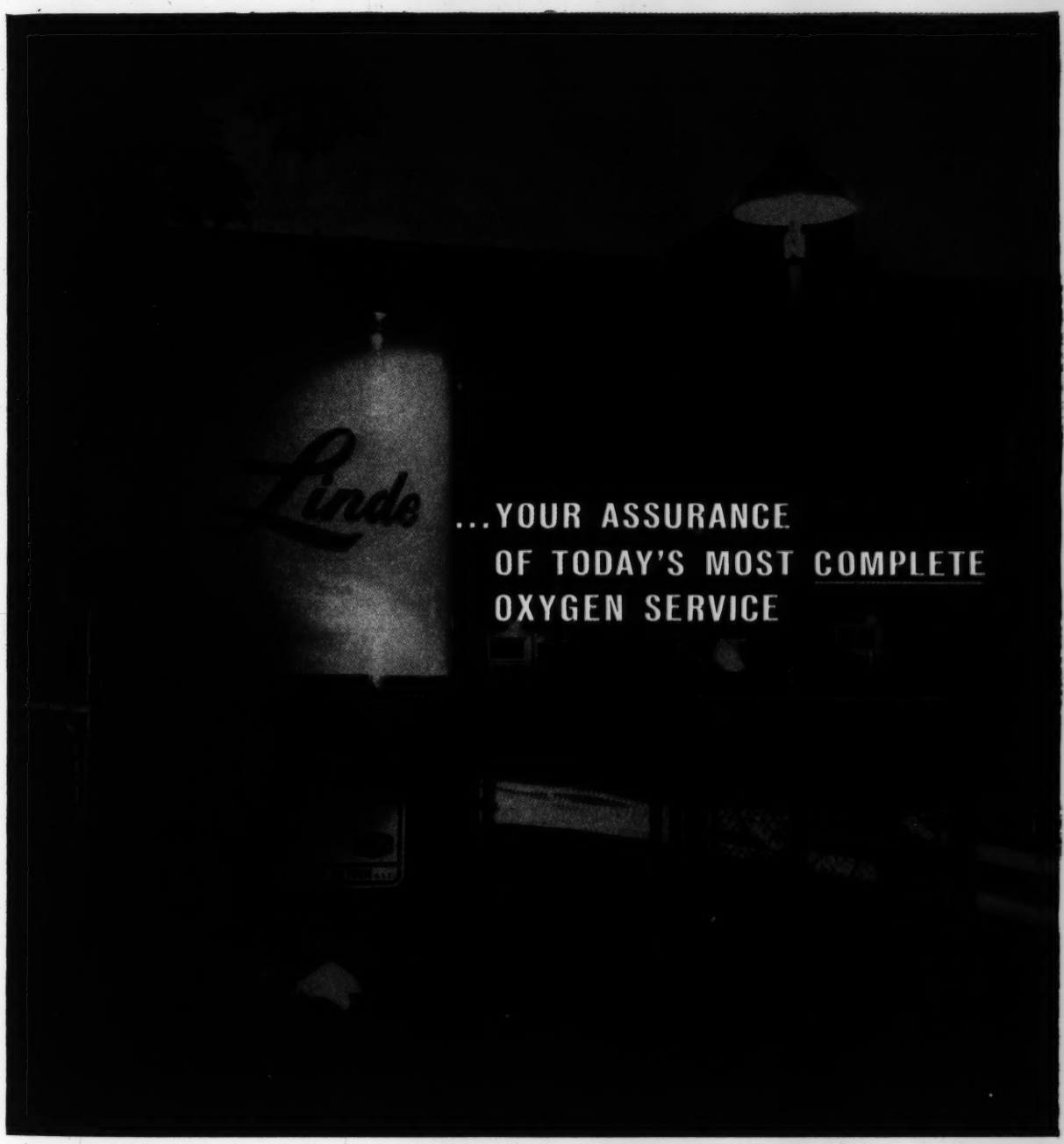

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FAIRY TALE LANE

Fantasy land for Small Fry

by **MARIE T. AUBUCHON, St. Louis, Mo.**

JOHNNY IS THREE years old. He has just learned that he is going to be in the hospital for a while and Johnny is a very frightened young man. He doesn't quite understand the meaning of the word, "hospital." He does understand that he will be separated from his mother and father and all the familiar things of home.

Then Johnny is taken to the Chester I. Mead pediatrics addition at Mercy Hospital, Bakersfield, Calif. Something wonderful happens. He is led through Fairy Lane, a hall that looks like a cobblestoned street. At one end of the hall a huge fairy castle with a moat and drawbridge rules over numerous little houses that line the street.

A nurse opens the door to what she explains will be Johnny's own little house—and Johnny wouldn't be a bit surprised to see Sneezy the Dwarf pop out. Here are things Johnny knows—beloved fairy tale characters who seem as real as his own playmates to him. Soft music comes from everywhere in this wonderful place. There are toys and gay little furnishings. If this is a hospital, then Johnny doesn't find it bad at all.

That is the way things will be when Mercy Hospital, Bakersfield, Calif., opens its new pediatrics addition. The 24-bed addition will occupy the entire top floor of the hospital and will be the finest kind of memorial for a man who dedicated his life to children and their health.

Dr. Chester I. Mead, who died at Mercy Hospital, February 11, 1959 had been the first trained pediatrician to settle in Bakersfield. He devoted many long hours to the care of the county's poor children and took a zealous part in the program for crippled children.

Teenage health was an important thing to Dr. Mead. He lectured many times on that subject, stressing the necessity of proper diet and calling attention to the fact that it is dangerous "to push" children between the ages of nine and 15 years. To Dr. Mead, childhood was a gentle thing, a lovely thing that had to be nourished with love and understanding.

Bakersfield grew and the people became aware that good pediatrics care was a great factor in developing good health in their growing families. As Dr. Mead worked with these people, his favorite dream was to have a hospital which would provide adequate beds and modern equipment for the children of the county.

Today, a non-profit organization made up of professional and lay people is conducting a drive for $300,000 to build the Chester I. Mead pediatrics addition at Mercy Hospital, Bakersfield. Called the "Crusade for Children," even the drive itself is geared around the things that children love. Each person who donates to the drive will be honored by having his or her name on a permanent scroll which will be located at the entrance of the new addition. These "Knights, Ladies and Squires" will thus be given a memorial for their role in a successful crusade.

The addition will be no ordinary pediatrics division. The whole thing will be geared to the new concept of care for hospitalized children. The entire structure will provide those things familiar to children in their own

(Concluded on page 142)

MERCY HOSPITAL, Bakersfield, Calif., as it will look after addition of a pediatrics unit which will occupy the entire top floor.

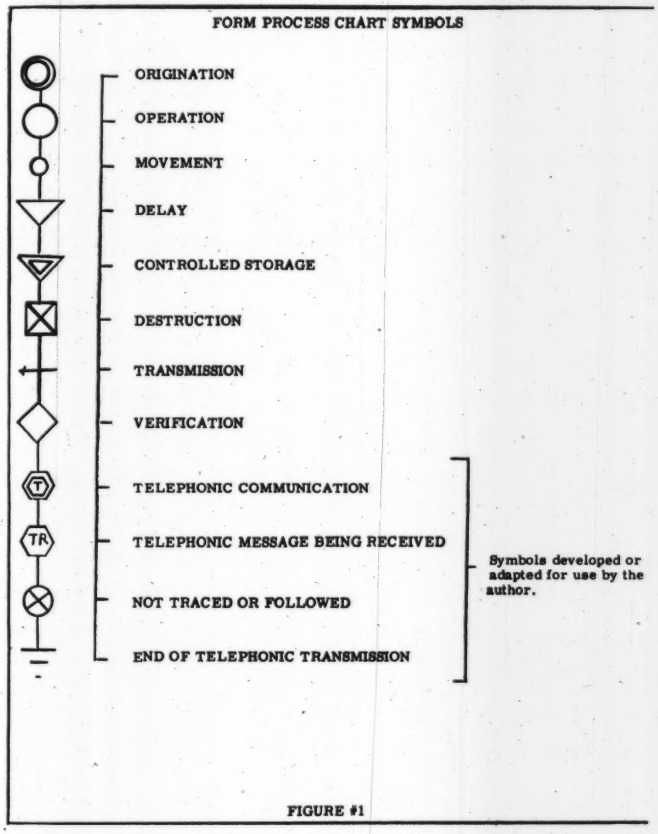

FIGURE #1

Work Simplification Applied to Hospitals

by **JOHN W. HANKINS, 1st LT. (USAF) MSC**
Scott Air Force Base, Ill.

IN THIS AGE of technical and scientific advancements, all of which have a tremendous effect on the limited finances of a hospital, neither administrators nor department heads can afford to overlook the necessity of conducting work simplification studies. Unfortunately, however, too few people are equipped to conduct such studies. Those who are prepared invariably encounter opposition from persons who consider work simplification studies a threat to their personal security. These include the worker who views the study as a thing which will put him out of a job and the supervisor who looks at it as if it intended to reveal his shortcomings. This is, of course, far from the truth, although some studies actually do have this effect. The salvation of hospitals lies in their ability to find a means of reducing work being performed in certain areas in order to utilize a person not needed on a specific job and to place that worker into another job which does require his services. By doing this, hospitals can move a step closer to the realization of their common goal, better and more efficient patient care.

This is one of the most important facts concerning the application of work simplification procedures to hospitals. The primary purpose of work simplification is to "simplify work." Hospital administrators are not always in a position to hire industrial engineers to accomplish such studies, so it is incumbent upon all department heads and other hospital personnel to acquaint themselves with some of the techniques which are used by industrial engineers in solving problems. At first glance, some of the symbols used in work simplification studies, such as methods of recording data, do appear most complex, but in reality they are not. Work simplification is nothing more than the application of common sense. For instance, when an office clerk decides to move a filing cabinet next to his desk because he is tired of continually walking back and forth to a cabinet located quite distant from his desk he is, in a sense, applying some of the principles of work simplification. We are accustomed to making these minor adjustments. However, when we approach the more difficult problems such corrections are not readily realized.

The acknowledgment of the differences between a simple and complex problem are described in two different terms. For the purpose of this discussion, a situation of the clerk mov-

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ing back and forth many times is a readily perceivable problem. This type of observation and correction might very easily be called a "Macroscopic" study.[1] Laboratory technicians are accustomed to such studies. For example, in performing a routine urinalysis, the technician will observe the specimen for color and amorphous material. On the other hand, when work becomes more complex and not readily discernible to the naked eye or mind, this then becomes a "Microscopic" study. In other words, the specimen must be examined much more closely. Both of these elements are important in every work simplification study as one represents the first stage of a systematic analysis, i.e., observation (this we shall discuss later), and the other, the second stage, that of breaking a problem down into its finer points.

As a final note before proceeding to the various steps used in conducting studies we must consider two other terms which are most meaningful throughout the study. They are the terms "Quantitative" and "Qualitative."[2] To the researcher, these terms are most important as the first implies a definite statement concerning the problem(s) i.e., "the nurse is required to walk 14 feet 13 times in one hour" as compared to the statement, "the nurse is required to walk quite a ways, many times a day." As one can readily see, the former is definitely a statement of fact. It is numerically specific, as compared to the latter which is indefinite.

Step One—Know the Problem

According to one of the foremost authorities, Dr. Gerald Nadler, the best way to attack any problem is to know the problem and to state it accurately.[3] Unless the problem is known, it is useless to attempt a solution. Furthermore, one must be able to limit the problem in order to avoid the difficulty of embracing a problem area too large for a researcher to study.

Wherever there is work being performed, there are bound to be problems. These may not, of course, be readily recognized by a person doing a specific job. In many cases, the worker may not be aware of problem areas which directly affect him. For the sake of demonstration, let us assume the existence of a problem which involves administrative work. Since this is an area in which hospitals should continually strive for improvement, the researcher would need to have a main objective. What does he intend his study to correct? In this case, his objective will be to eliminate unnecessary administrative procedures. This is an area which embraces the entire hospital. Since he must limit the problem, he must then confine his study to a specific area such as the business office.

At this point it would be wise for him to make a "Macroscopic" analysis of the situation. In other words, "observe what is going on." After he has completed this observation he would,

■ SISTER MARY VISITATION, C.S.J., administrator of St. Mary's Hospital, Waterbury, Conn., calls her staff "the most important public in the institution." She proved she believed this statement when during the golden jubilee year, 1959, she planned the events around the various personnel groups associated with the hospital.

There was a formal banquet for the board of directors and medical staff; a solemn high mass of thanksgiving for the religious of the community and representatives of house personnel; a scientific session and dinner for medical staff physicians in hospitals throughout the state; a mass and communion breakfast for the alumnae of the hospital's nursing school; a jubilee banquet for present nursing school students; an alumni day for all past and present members of the hospital's medical staff; a jubilee banquet for the entire staff of the hospital, and closing the year, a high mass of thanksgiving scheduled for New Year's Eve. At many of these dinners the sisters who staff the hospital served the guests.

No wonder St. Mary's Hospital has such loyal staff members—they know they are appreciated.

[1]The two terms being described were taken from a lecture in Work Simplification given at Washington University, St. Louis, Missouri, by Mr. A. Bruckner II.

[2]Ibid.

[3]Gerald Nadler, Work Simplification (McGraw-Hill Book Co., 1957) p. 17. Note: For the purpose of this article the general approach to the scientific method of analysis of problems suggested by Nadler, even though somewhat modified, has been used.

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by a mental process of elimination, decide how to conduct this study. It is at this point where he would decide to utilize one or more of the many tools of an industrial engineer's trade, i.e., a Form Process Chart (FPC), Product Process Chart (PPC), Man & Machine Process Chart (M&MPC), Flow Diagram and perhaps many others, depending upon the nature of his study.

Step Two—Get the Facts

As in *Step One* it is necessary to know the problem before attempting a solution. The adequate solution to any problem depends upon one's ability to acquire facts—the facts as they are, not as one thinks they are or should be.

How then, to arrive at the facts and how to record them? Obviously, it would be most difficult for the researcher to record all information on a scratch pad without feeling that he has lost some, if not most, of the information gained. It calls for a scientific method of approach. It is here that he must learn to use the symbolic method of recording information.

In work simplification studies, symbols (Figure 1) depicting various types of operations, movements, delays, etc., are used in such a way as to indicate work situations which are actually taking place. Everything which happens to the person (if a Man Process Chart is being used) is recorded just as it happens. How far he moves, what he does when he gets there, how long it takes him to get there are all recorded. The researcher now has a visual index of the work taking place. The trained observer can then visualize all activities.

During the entire study, the researcher must be prepared to record ideas as they occur; comment on deficiencies and be careful not to omit important facts. On occasion he will find it necessary to develop certain symbols to cover situations not normally covered by present work simplification symbols (Figure 1). He should be prepared to record ideas which may have been overlooked or not heeded by management. It is important that the researcher recognize the significance of tact and he will truly need diplomacy. He must respect the ideas of the worker since they are working at the job and know much more about the task being done than he does. He must also be prepared to quell any fears that a worker might express to him on the spur of the moment. A worker might ask, "What are you trying to do—put me out of a job?" He might tactfully answer, "Oh no, what we are hoping to do is to make your work easier by improving the way your work is being done."

It would be well for the researcher to spend a few minutes initially to explain his purpose. This is good for morale and helps to cement management-worker relationships. Where it is obvious that a job might be eliminated, it would be wise for management to keep the workers well informed as to what might happen and at the same time quell their fears about being removed.

The above are important areas of consideration which cannot be neglected whenever work simplification studies are being conducted. It would certainly be foolhardy to overlook them. After recording all the facts about a specific job, it is important that the researcher supplement his process chart by either a work place diagram or flow chart.

Step Three—Get Ideas

During the entire study, ideas are being developed by the researcher. From the very onset of the study it has probably been evident to the researcher that there has been duplication of information, effort, excessive workloads in certain departments, time delays etc. Knowing the problems and the facts about the problem is not enough. His purpose is to find a suitable means of overcoming these problems. There are certain ways of doing this. One of these is the use of a Suggestion Guide. This method requires a systematic examination of the Original Process Chart in order to get ideas. The suggestions are recorded in such a way as to accommodate the various changes which may take place, i.e., a material, sequence, design, equipment or method change and of their effect upon each other.[4] After all ideas have been recorded, no matter how silly they may appear, he is then ready to select the best answers. During the selection process, the re-

[4]Ibid., pp. 24-25.

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"It would appear, therefore, that from this limited experience with 17 desperately ill patients, parenteral novobiocin [Albamycin] is therapeutically effective and offers a reasonable expectation of a favorable response even in seemingly hopeless cases."

Garry, M. W.: Am. J. M. Sc. *236*:330 (Sept.) 1958.

"Staphylococcal sepsis, particularly as it appears within the hospital environment, continues to represent a serious and difficult therapeutic problem. . . . It would appear that novobiocin [Albamycin], like other broad-spectrum antimicrobial agents, will be of clinical value in a certain number of staphylococcal infections."

Colville, J. M.; Gale, H. H.; Cox, F., and Quinn, E. L.: Antibiotics Annual 1957-1958, p. 920.

The use of Albamycin has not been accompanied by systemic toxicity — renal, hepatic, or hematopoietic. Side effects (such as skin rash) have been minor in nature, and those that do occur are easily managed.[1-3]

1. Garry, M. W., *op. cit.* 2. Editorial, New England J. Med. *261*:152 (July 16) 1959. 3. Nunn, D. B., and Parker, E. F.: Am. Surgeon *24*:361 (May) 1958.

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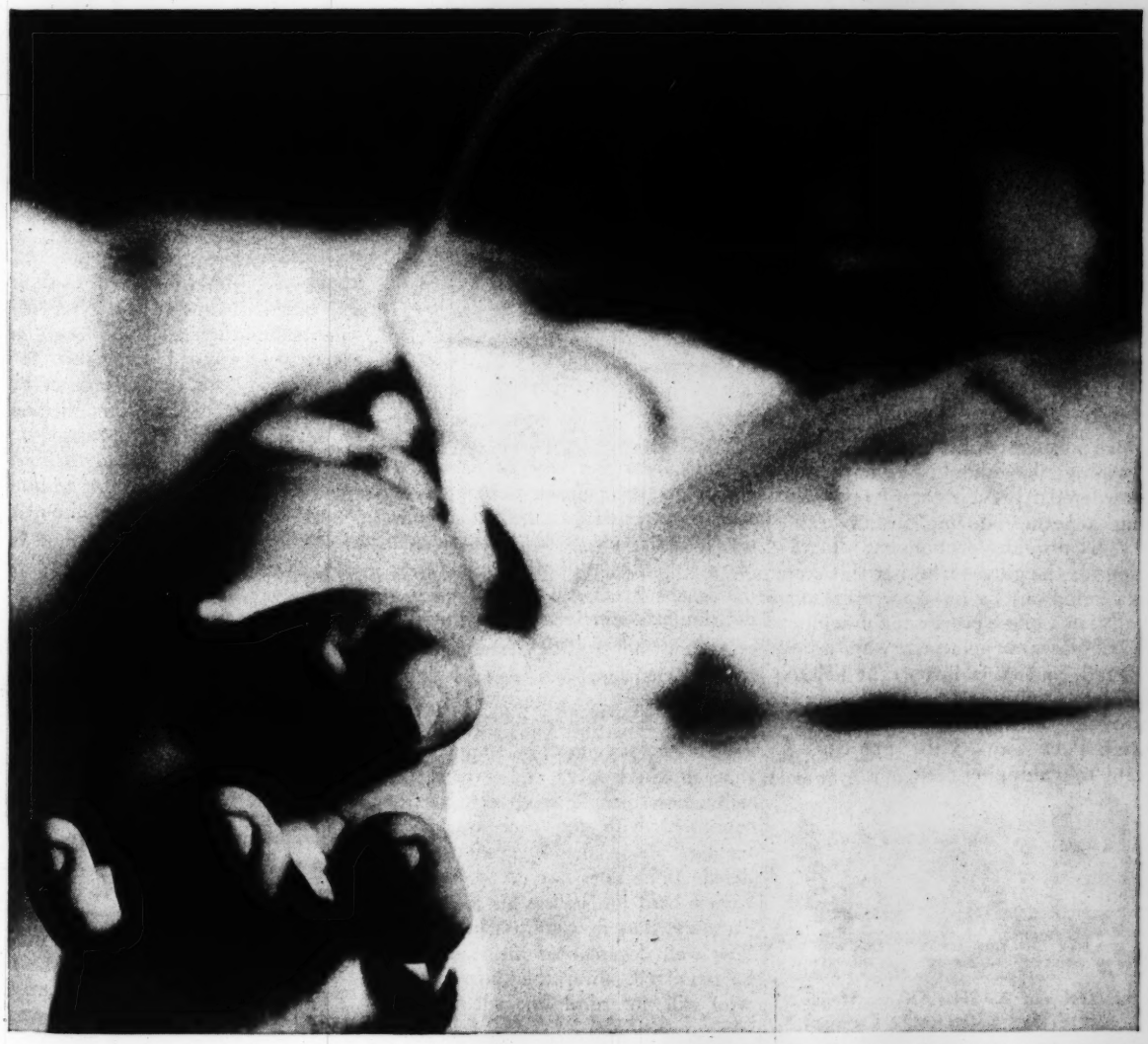

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searcher may be astounded to find how often he has overlooked something in one suggestion only to pick it up in another and how he may be able to combine one or more of the suggestions toward the solution of a problem.

Step Four—Select the Best Ideas

Obviously, the researcher is going to come up with more than one idea. He must be prepared to select the best ideas. As pointed out, previously, he may find that he can incorporate many different ideas into one. The ideas themselves will vary, but the most important one is the one which will stand the endurance test, i.e., the one which can show a savings in terms of dollars and cents. It must be pointed out, however, that savings may not always be realized or more money spent. Rather, it may mean the improvement of a system which will be a benefit to all concerned. These benefits include the comfort of the patient and the health and welfare of the workers.

It is natural to hope there will be a savings in money. Before he can develop a system or idea which best answers the problem, the researcher will be required to develop a proposed process chart and flow diagram as well as to develop a cost analysis chart of the systems which he thinks are the best.[5] By the method proposed by Nadler, one is able to compare the present cost to that of the proposed system. Even the cost of salvaging equipment, etc., of the old system is taken into consideration. The cost for installing the new system is considered so that the final authorities can verify the results of the study and make a decision accordingly.

As one can see, the researcher has run a "chain of natural evolution." However, he cannot ignore this important fact: Before he submits a suggestion for change, it is imperative that he check over and over again with those people who are directly concerned with the problems, their feelings about the suggestions tendered. If he does not do so, he may have a hard job selling his ideas. He must also bear in mind that no matter how well documented his study may be there will always be those people who will not admit the adequacy of his suggestion(s). In this case it is important that the researcher have good rapport from the start so he will be able to determine which persons (if any) have a tendency to be uncoöperative and can make adjustment for their remarks or evaluation. A good, careful study will help to convince some skeptics one is bound to find. This involves another of the many steps required to arrive at a solution.

[5]Ibid., pp. 202-203.

Step Five—Detailing the Job

It is most important that the details of an idea be presented in such a manner that they can be easily understood. This information must be written so that the worker, supervisor or anyone else connected with the job can understand and put it into operation with a minimum of difficulty. No detail must be omitted. For instance, if the job required the use of self-sealing envelopes for the packaging of needles and the words "self-sealing" were omitted, the purchasing agent would purchase the wrong envelopes, causing an unexpected delay.

Every person concerned with the job must have clear cut instructions as to how, when, why, where, who and what about his job. These are most important. The researcher must insure that such information is provided when submitting his plan. There are a variety of ways of doing this. It is not necessary, for the purpose of this discussion, to depict such methods. However, it should be emphasized that the steps which the worker or supervisor is required to take must be listed in accordance with the requirements of the job. For instance, *step one—turn on switch*—etc.

Step Six—Reviewing the Job

No job or suggestion for change is acceptable without a complete review to obviate the chance of omission. It is always wise to review the proposed system, as depicted on the chart, with those people who are involved all the way along the line in order to assure that nothing has been overlooked. Even in cases where haste is a requirement, a careful approach to the problem will limit the number of errors which would occur. Wherever possible, it is very important that the researcher be given ample time to accomplish his mission. In any event, the job which has been proposed must be reviewed thoroughly before being submitted for approval.

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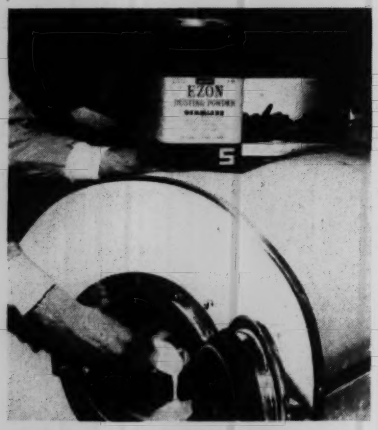

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Step Seven—Testing the Job

Not all situations lend themselves easily to testing. Wherever possible, a job should be put on a test basis or an attempt made to simulate the proposed system as if it were actually in use. By actual test methods one is able to verify the validity of the proposed system. If all goes well, the system might be adopted. If the system fails, only a minor revision or readjustment might be necessary to correct it. If the study has been done properly from the start, minor deficiencies should not be evident and the system should stand up under the hardest of criticism. (It can be anticipated that there will possibly be discrepancies but these can most likely be worked out. This would most likely be true of extensive operations. In hospitals where there are many little jobs which can possibly be consolidated, the chances of error would be almost non-existent.)

Step Eight—Installing the Method

After all deficiencies, discrepancies, etc., have been eliminated or worked out, after the method has been tested and accepted, the next step is to install the method. It is important that the researcher work hand in hand with those people who must install the method as well as those who must work the proposed system. The system will be new to them, but with the researcher present, all questions can be answered or clarified immediately as he (researcher) knows more about the entire system at this point than anyone else. The researcher should be expected to be able to train the people involved or else have someone else who is qualified to do the job for him.

Step Nine—How Much Should Be Expected?

It would be ridiculous to expect nothing out of all these steps. What *should* one expect after the study is completed? Obviously, one should expect that the main objective for which the study was made has been realized. In the case of the business office which was mentioned earlier, the reduction of administrative procedures should have been realized. This improvement must, by necessity, have been an economical and an efficient one. No increased workload should be evident unless otherwise agreed to by all concerned.

Where Can Work Simplification Be Applied?

Wherever work is being performed, work simplification studies can be used. Whether it is in the surgical suite, central service, business office, food service, laboratory service—or even in the home—one will be able to use and derive the benefits which are available through the use of work simplification methods. ★

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Classroom Instruction by: Mr. A. Bruckner II, Industrial Engineer instructor, formerly a member of the faculty of Washington University, St. Louis, Missouri. To him the author owes a deep sense of gratitude for his excellent, sometimes tiring, instructions in the art of using work simplification.

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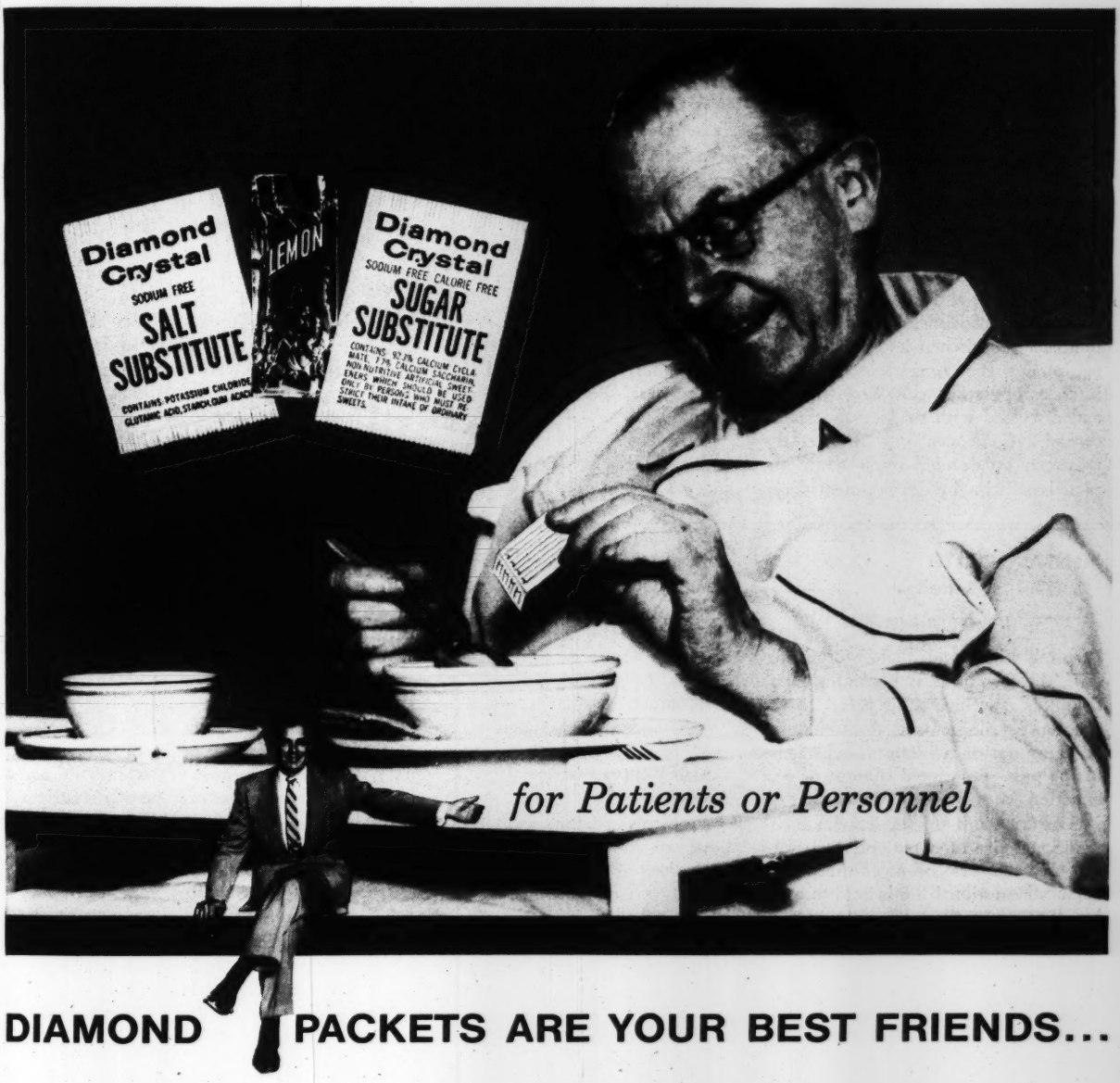

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FOOD FACILITIES

(Begins on page 78)

building is completed, an efficient food service operation is their responsibility; also, it is most likely that they will have to live with any mistakes for many years.

In industry, models and templates are widely used for the layout of manufacturing processes. This method shows how to use a given space to the best advantage and how to work with a minimum of labor. With the aid of templates of kitchen and food service equipment, the complete sequence of kitchen operation can be visualized and discussed with the personnel concerned. If changes appear necessary, they can be decided upon while the plan is still in the development stage, thus avoiding the heavy expense of rearranging or discarding expensive equipment later.

Plant engineers refer to transportation time for tools and materials as "idle time." Food is no better, nor is it more valuable, if it is moved eight or 10 times in the process of being prepared and cooked, than if this is accomplished by moving it two or three times. The same rule holds true for the distance moved. A food product is no better if moved several hundred feet back and forth in the kitchen than if it is moved only a few feet throughout the preparation and cooking process. Transportation time represents labor cost.

Hospitals can well afford capital outlay for equipment which will pay for itself many times in savings, either in labor or materials. An efficient food facilities layout which eliminates three or four workers from the payroll will show a substantial savings in a year. Automation does not necessarily have to be limited to manufacturing processes; it can also be applied in limited fashion to many small operations in various departments. This requires only the limits of imagination.

In large hospitals and institutions as much care and thought should be given to the food facilities as the industrial engineer gives to factory or plant layouts. Kitchens are food factories; therefore, let us look at the industrial engineer's method of attacking similar problems, and begin to develop a scientific basis for planning food facilities. ★

MENTAL HEALTH

Scheller

(Begins on page 90)

hospitals with an adequate professional staff, the technique is becoming more common. Psychoanalysis refers to the effect of psychodrama as abreaction, the bringing out or reliving an experience of the past. Emotional content of past experiences of an unhappy or damaging nature tends to clog up the entire emotional life of a patient; and until this residue has been eliminated, a balanced emotional life is hard to come by.

Always it must be kept in mind that the psychiatrist, the psychologist and the social worker have no mechanical instruments for the purpose of diagnosis of treatment but must rely entirely on the interpretation of the behavior as it is manifested externally or from hidden recesses of the unconscious. It is no simple task, but it is extremely encouraging to note the efforts currently being made by professional experts, by research teams, to learn more about the factors causing mental illness, and the devoted and patient work of large staffs dealing with individuals who are suffering from mental illness.

Problems of mental health, many believe, are at the basis of most social problems. A good family is one in which good mental health prevails, in which there is good understanding and a good relationship between the individual members of the family, in which the roles of father and mother and children are played adequately, in which ultimately, love prevails. Mental health is not an abstract theory; it is something lived. When mental illness strikes a family, all members of a family are affected, and if it is not prudently attended to, the effects may be harmful to the individual members of the family as well as to the patient himself.

In his later years, Pius XII showed a marked interest in the progress made by the disciplines of psychology and psychiatry. The necessary precautions he gave in addresses to psychotherapists when dealing with the human person are balanced by a whole-hearted encouragement, "that your work may ever increasingly penetrate into the complexities of the human person, that it may help to remedy its weaknesses and meet more faithfully the sublime designs which God, its Creator and Redeemer formulates for it and proposes to it as its ideal." ★

PEDIATRICS

(Begins on page 132)

homes or nurseries. Well-known fairy tales will provide the decorations. Each facility will represent a different fairy tale and the entire scene will be carried out from the entrance to the doorway of each room.

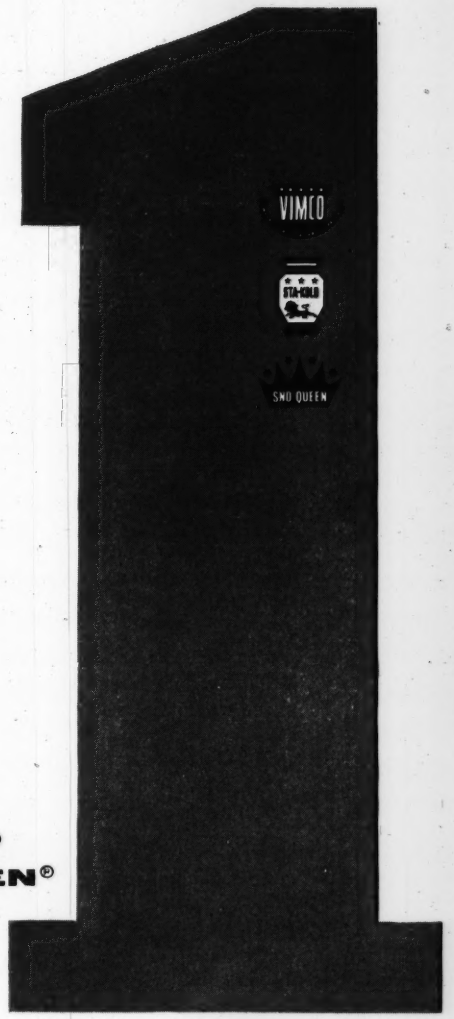
There will be Fairy Lane, an enchanted place flanked by little fairytale "houses," leading to a huge mural of a castle with the drawbridge down inviting visitors to enter the realm of the Fairy Queen herself. Above is a ceiling made to look like a soft night sky with shimmering stars and clouds.

Each little "house" is really a well-equipped hospital room. There is piped-in oxygen, electric beds, recessed reading lights, lavatories, scrub sinks for doctors and each room will be completely soundproof. There will be a TV intercom at the nursing station, a large waiting room for parents, a well-equipped playroom and isolation facilities. The playroom will boast of an aquarium, ant village, television, and numerous toys. Music will be piped into all rooms.

Dr. Mead would have been delighted with the imaginative decor of this addition. He knew the terror a child feels on being separated from his parents. But when the child, like our fictitious Johnny, sees Fairy Lane, he will realize that here he will be with people who understand children and the lovely world of make-believe.

Parents will know that behind the picturesque exterior there are facilities all doctors need for their patients—good nursing care, laboratories, diet kitchens and therapy.

Today there are 90,000 children in the county and less than 100 hospital beds available for their use. The new facilities at Mercy will greatly assist in the care of these children and will relieve to some extent the demands upon the facilities for adults. And the magic of medicine will be worked in an aura of fantasy! ★



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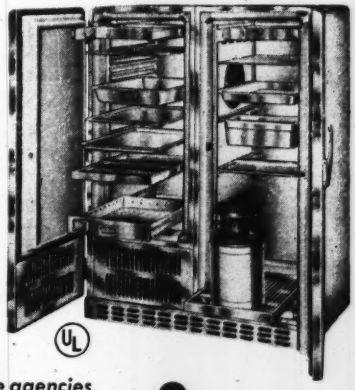
For years, Victory refrigerators have been the *first choice* in the world's finest kitchens. And there's good reason, too! As a radical innovation we pioneered and produced the first all-metal refrigerators. We then created, patented, and made available the *first* interchangeable interiors which could be changed or rearranged in minutes — without tools. Today Vimco®, Sta-Kold®, Sno-Queen® refrigerators continue to be first with the foremost features. *That is why more and more experienced buyers are demanding Victory refrigerators . . . first of all!*



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- Salad-Dessert Refrigerators
- Combination Normal Temp. and Freezers
- Self-Contained
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Compact Dishwasher

Here is a compact, completely timed-controlled dishwasher priced well within the average small kitchen budget. A popular straight-line, counter-top or under-counter machine, the Hobart Model SM-6T2 automatically controls wash, dwell and rinse operations—eliminating the human element that often accounts for poor results, and the cost of supervision. Compact and simple to operate, single control sets timed operation. "On-off" pilot light indicates machine operation. Another important feature: manual rinse for glasses always available.

Whatever your dishwashing requirements and kitchen layout, you'll find that one of the more than 50 Hobart models is specifically designed to give you compact efficiency and highest standards of sanitation—with more *real savings*. See your nearby Hobart dealer or write The Hobart Manufacturing Co., Dept. 302, Troy, Ohio.

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The World's Oldest and Largest Manufacturer of
Food, Bakery, Kitchen and Dishwashing Machines

BETTER BUY DISHWASHERS...

BETTER BUILT BY HOBART

(Begins on page 62)

research will give way to pinpointed research and it will be considered respectable and worthwhile to study the proper height of the lavatory and whether it should be placed in the toilet room or in the patient's room; and whether philosophies propounded in prepayment fields stand up under the microscope.

11. *The Unkown Future*—Let's meditate for a moment on the postanesthesia recovery room—so simple an idea, so worthwhile from every viewpoint, and yet so late in being conceived. How does one build to allow for the advent of such a program which comes out of the blue? Many an old hospital is deprived of this worthwhile facility because of space. Too many shortcomings in space have been revealed since the recent World War; consequently we are all trying to buy hedges for the future. We are stressing land for expansion, land for parking, land for doctors' office buildings, lateral expansion for service and ancillary facilities and methods of adding nursing units. Flexibility and wider vision will be the fashion for tomorrow's planners.

Summary

■ Tomorrow's hospital is not the subject of one paper, one institue, one year's study, or one person. It warrants millions of dollars for study, thousands of researchers and a continuing program that perhaps will always be today pursuing the elusive tomorrow.

This paper invites your attention to a few areas in tomorrow's hospital which may change or need study:

1. Nature of the Hospital.
2. Size of the nursing unit.
3. Width of patient's room.
4. Patient comfort.
5. One-man planning.
6. Unorthodox attention getting approaches.
7. Future of cancer patients.
8. New programs added.
9. Old programs dropped.
10. Impact of inflation.
11. Space for diagnostic tools.
12. Hospital infections.
13. Tuberculosis in the general hospital.
14. Psychiatry in the general hospital.
15. Chronic care in the general hospital.
16. Caring for the sick aged.
17. Prepayment.
18. Automation.
19. Departmental relationships.
20. To break or tie with the old structure.
21. Functional research in hospital design by hospital oriented people.
22. Hedges for the future.

Planning cannot be done with sketches, lines and symbols alone. It must be done with programming. Administrators and trustees cannot sit back any longer and "let Jack do it." ★

Plan Now for Milwaukee!
C.H.A. Convention, May 30-June 2

(Begins on page 66)

lieved of messenger duties and other tasks that will help them away from bedside care.

As the planning of the nursing unit goes on and the constant questioning proceeds as to the validity of traditional arrangements, it is inevitable that a constant inquiry is likely to be "How can we bring the items required for bedside care as close to their point of use as possible?" Thoughtful planners have achieved this in a variety of ways, but new approaches are always possible once planners are convinced that departure from yesterday's hospital planning is not necessarily heretical. It does take courage to be original, but a fresh approach is insulated from ridicule if it is based on sure and solid study.

One final word of caution about preliminary plans is that the word preliminary cannot with impunity be interpreted literally. Every possible decision that can be made in the preliminary phase of work should be made. When the planning team has finished with the preliminary drawings, every detail should be so well thought out that no changes will be required in the working drawings. Every item of counter and casework should be decided on with care. Under-counter cupboards and high cupboards should be scrutinized with the question as to whether or not they are indispensable. A survey of many hospitals will show that many inaccessible pieces of casework are dispensable. Decisions of this kind with respect to all manner of equipment and finishes will release budgeted construction funds for use in the upgrading of other elements of the building.

Again, at the conclusion of the preliminary drawing phase, the architect will provide another and more authoritative estimate for comparison with budget. If any sacrifices to budget are to be made, they must be made now, since adjustments in the working drawing stage can be difficult to the point of near frustration. For over-all comfort, it is far better at this stage to be pessimistic as to how bids will come in than to take the optimistic view and find that bitter sacrifices must be made after the bids are opened.

Some administrators reading the foregoing may at first glance feel that the program outlined calls for the talent of a super-administrator. This is far from the case. Any administrator adequately qualified for the administration of the hospital being planned should find the task easily within his or her capabilities, provided there is a willingness to accept the challenge of hard work and logical reasoning. As stated earlier, however, administrators must be prepared organizationally to release much of their time for the planning effort.

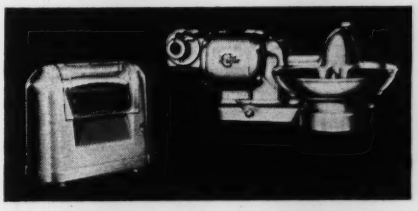
The consultant can help simplify the task if his resources are used to augment the administrator's time and faculties; but—in the context of this approach to planning—no one can successfully provide a substitute for the leadership of the administrator. When ready to embark on a hospital planning project, administrators who accept responsibility for guiding the planning team must train themselves to challenge opinions and be prepared deliberately to test and examine every recommendation, no matter how authoritative its source appears to be. Their motto should be: "Probe and analyze; take nothing for granted." ★

The *new team* of Hobart food cutter and tenderizer in your kitchen can put a new item on your menu. It's a new and more delicious tenderized steak.

How? The Hobart food cutter blends the fat and flavor of suet with low-cost shank, neck and trimmings... removes all tough tendons, gristle and sinews. Quickly processed, the product is then knit into tender-taste, juicy, waste-free, tenderized steaks by the Hobart tenderizer—a taste treat that builds menu variety.

The same food cutter with its convenient attachments can be profitably used to produce a wide variety of meat, fruit, vegetable and salad items...in fact, its kitchen-wide utility is limited only by your imagination. Call your Hobart Representative today for a demonstration of this menu-building team—right in your own kitchen. The Hobart Manufacturing Co., Dept. 302, Troy, Ohio.

Menu-Building Team...



of Hobart food cutter and tenderizer speeds preparation of appetizing specialties for better service to patients at lower cost.

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BETTER BUY MACHINES...

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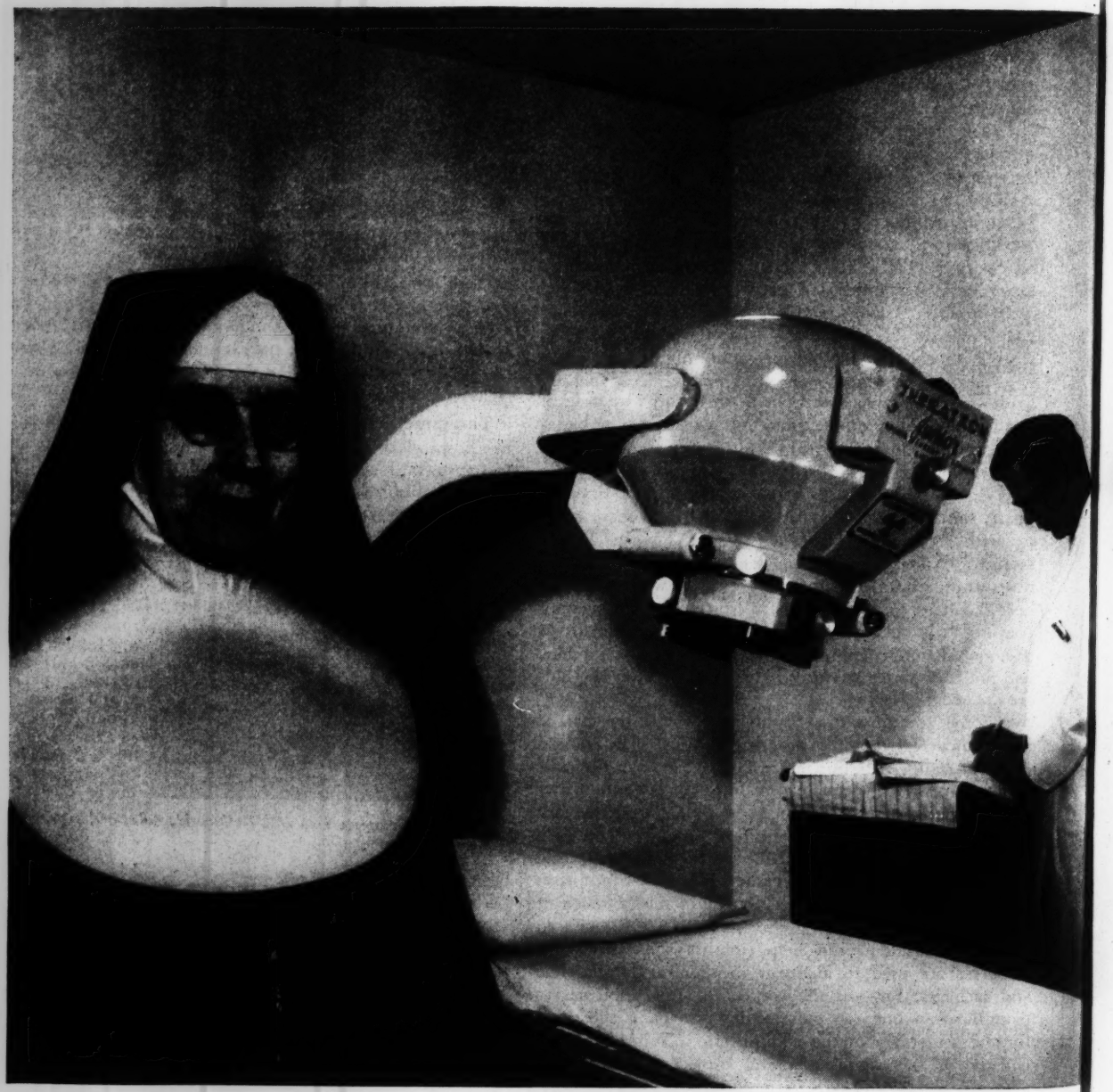
Sister Rita Clare, Administrator of
St. Mary's Hospital, Minneapolis, says:

"Honeywell temperature controls cut costs and improve



Sister Rita Clare in the X-ray Department of St. Mary's Hospital. St. Mary's Hospital is one of the largest hospitals staffed by the Sisters of St. Joseph of Carondelet. The Order was founded in France in 1650. Today, more than 4,700 Sisters belong to this Order. They operate schools, colleges and hospitals throughout the United States.

help us patient care"

Architects: Hills, Gilbertson and Fisher Architects, A.I.A., Minneapolis
Consulting Engineers: Bruch, Morrow and Knafla, Inc., Minneapolis
General Contractor: M. J. McGough Co., St. Paul
Mechanical Contractor: J. M. McClure, Kelly and Co., Minneapolis
Electrical Contractor: Batzli Electric Co., Minneapolis

Honeywell individual room thermostats free busy nurses from chambermaid chores. And a Honeywell control center enables one man to supervise the entire heating system

"With payroll the biggest part of our operating costs, anything we can do to increase the efficiency of our staff is money well spent," says Sister Rita Clare. "Honeywell room thermostats free nurses from adjusting radiators and opening and closing windows for more professional duties. At the same time, heating costs are reduced because there is no overheating and because thermostats in vacant rooms can be turned down."

Honeywell also installed a Selectographic Supervisory Data-Center* in St. Mary's Hospital. This unique control center enables the building engineer to supervise the entire heating and ventilating system from his office. For example, he can check temperature and humidity in all surgery and delivery rooms and nurseries. Alarms are also provided for the oxygen and nitrous oxide systems.

Selectographic eliminates constant trips throughout the hospital and assures the finest, most economical comfort at all times.

To learn how Honeywell controls can help reduce the cost of operating your hospital, see your architect or engineer. Or call your nearest Honeywell office. If you prefer, write to Honeywell, Dept. HP-3-56, Minneapolis 8, Minnesota. ** Trademark*

A unique feature of the Selectographic is an intercom unit which enables the engineer to listen to penthouse equipment and check its operation, as he starts and stops it from the control center.

Honeywell

First in Control

SINCE 1885

75th YEAR — PIONEERING THE FUTURE

(Begins on page 72)

majority of service personnel do not enter main medical and patient areas.

3) The nursing units which have been designed are rectangular, incorporating the advantages of a circular nursing unit, or what might be termed a refined double corridor scheme. This highly-efficient nursing unit will accommodate 40 beds and is adaptable to various types of service, varying from chronic or nursing home facilities to intensive care. This 40-bed nursing unit is connected to an element containing elevators and a central stairway. The expansion of additional nursing units will be in the form of an additional tower, which also will connect to the same vertical circulation element, therefore duplication of elevator service will not be required, although one more elevator will be added when the second nursing unit is built. An added advantage to this solution is that the noise of this circulation is kept outside the nursing unit so that there is less interruption of service and greater control of visitor-patient traffic.

A tentative master plan has been determined to include a nursing home, doctors' offices and research facilities on the site; the plan has been so developed that these additions can be made without interruption of existing services and facilities.

In order to facilitate construction during the short building season and to assure that the building is enclosed during the first summer so that work can proceed on the interior during the winter, fireproofed steel was chosen as the structural building material. The nursing tower will be enclosed with a curtain-wall construction similar to that used in many office buildings in the northern portion of the United States.

Sun and light will be controlled with manually operated vertical aluminum louvers which will close over the glass areas to give protection from winter winds as well as summer sun. The louvers also will control the amount of light in patients rooms, eliminating the need for shades or drapery. These double thickness louvers would serve as protection for the glass areas in the event of enemy military action.

Every effort has been made to provide a hospital facility that will create an aura of warmth and confidence in an area where long winter nights add to the emotional problems of the ill. In the reception-lobby area, for example, a large fireplace will be visible to patients and visitors as they enter the hospital. Interior structural and finish materials have been chosen for their color and texture.

Groundbreaking for the five-story, 97,000 square foot structure—the first major project initiated since Alaska attained statehood—will take place in April, 1960. Cost of construction, not including fees or equipment, is $4,250,000. Operation of the new facility should begin in the fall of 1961. An Anchorage architectural firm, Edward Crittenden and Associates, is handling construction management on the project.

When the doors of Providence Hospital open, the great efforts of the Sisters of Charity of Providence will have been rewarded, and they, true to their ways, will already be working toward another needed facility in another growing area. ★

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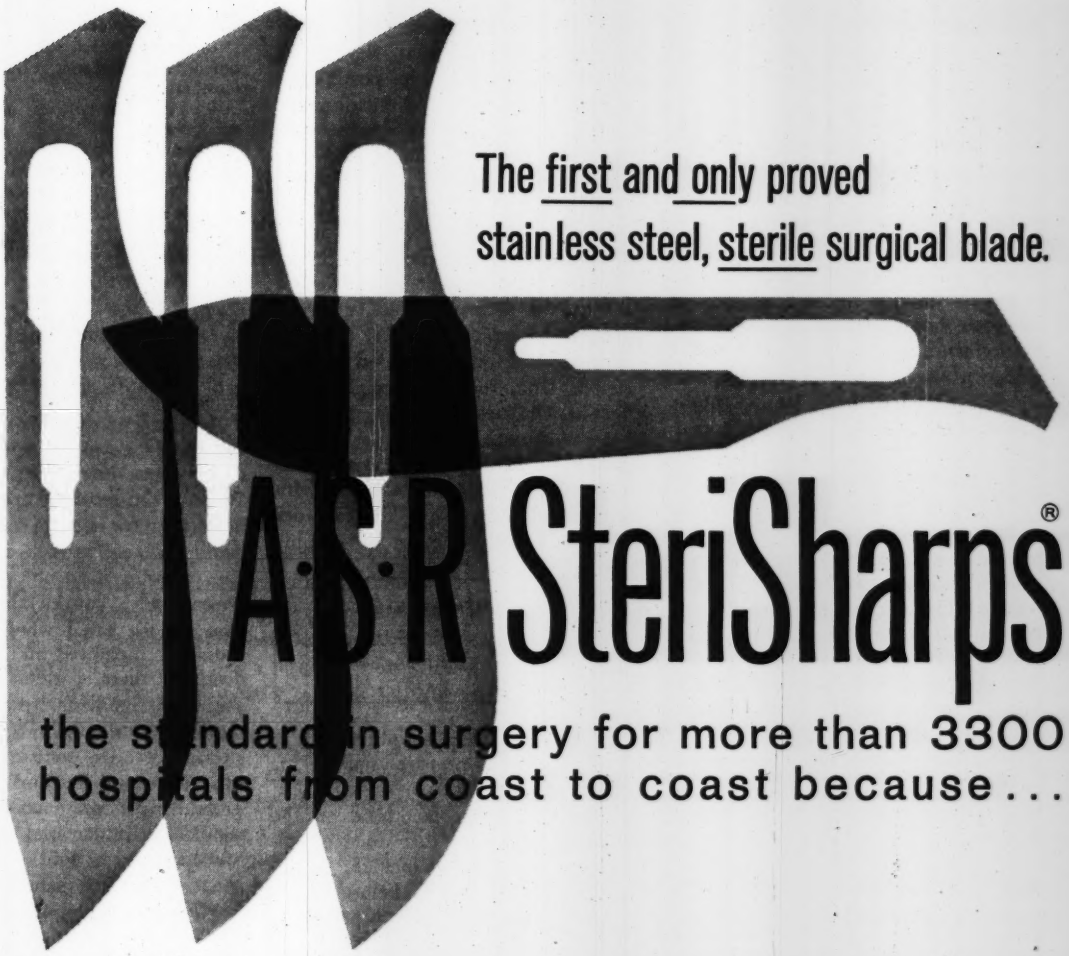

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(Begins on page 100)

whether it be a new or old building, must be planned for maximum efficiency, order and safety. The environment must be conducive to the well-being of patients and personnel. The head nurse must carry forward this concept. Her plans for physical facilities must provide for the supervision of good housekeeping facilities, climatic factors, such as heat and ventilation, for the comfort of the patient; lighting, shades, bed lamps, night lights, reading lamps, etc., which may affect the well-being of patients; functional and esthetic arrangement of furniture, flowers, pictures, etc. for the most positive effect. We should not overlook nor underestimate the hospital atmosphere in terms of the human setting. Elements such as noise, personnel talking and socializing, poor storage, general disorder and other tension-producing factors have a direct bearing on morale. Negative attitudes may be formed in a poor environment. The output of work may decrease and most contagious of all are the tension and stress factors transferred to the patient.

Disastrous fires in institutions have emphasized the need for good safety programs. The head nurse should plan to educate and counsel all personnel on the unit in the prevention of fire hazards, proper storage of equipment, proper care of equipment, emergency measures for disasters—a program of preparedness, knowing how to evacuate patients to safe areas, etc. With a little foresight and concern many lives could be saved, but most important of all is teaching and practicing safe habits of living. A truly positive program will impress the patients also and send them home as ambassadors of safe living.

In the area of materials, supplies and equipment, the head nurse is concerned with inventories and analysis of the needs of the unit. The new labor and time-saving devices should be considered whenever feasible. Rather than cope with inadequate, obsolete and improvised equipment the professional staff should be free to spend most of their time in the area of patient care. The routine nature of inventories, check lists, requisitions, etc. should, whenever possible, be delegated to a clerk. In fact, much of the office administration should be delegated to an efficiently trained clerk. Equipment throughout the hospital should be standardized and whenever possible located in the same place on all units. This procedure facilitates the reorientation of rotating personnel and improves efficiency in the unit. Modern, complete and adequate materials should be available at all times in all units. Failure to have necessary equipment reduces the time spent in caring for patients, the primary objective of the hospital and nursing service.

An ongoing program based on suggestions from the staff should be in effect as it relates to the simplification of the work area, the need for and use of supplies. Economy measures should be instituted when necessary. Joint planning of all who use the facilities will equalize the burden of keeping the unit adequately supplied and at the same time prepare nurses for charge responsibilities.

CONVENTION DATES

Milwaukee	1960
Detroit	1961

The head nurse should be on the alert for elements that reduce efficiency. Time robbers include: 1. unnecessary walking—unplanned trips. 2. prolonged use of the telephone, 3. long conversation of a useless nature, 4. failure to delegate clerical duties, 5. a crisis mentality (every problem is a crisis) and 6. prolonged meetings that are nonproductive, nor constructive.

These time-robbers can be eliminated when limits to do a job is defined. Education, counseling and supervision can bring about efficiency in the nursing unit. Necessary routines should be simplified as much as possible so that more time will be available for creative tasks and specialized functions.

An efficient system of controls for carrying out administrative policies and routines should be set up and included in the orientation program to the unit as well as in followup and evaluation procedures. Unit manuals facilitate routine procedures and may include:

1. Personnel directory,
2. Hospital organization chart, showing lines of authority,
3. Relationships of one department to another,
4. Responsibilities, duties of personnel, staff, maids, etc.,
5. Daily activities outlined,
6. The physical layout and unit set-up,
7. Copy of orientation program,
8. Patient teaching classes, a list of content, e.g., diabetics, cardiacs, amputees, colostomies, etc.,
9. Personnel policies, request holidays, time lost, etc.,
10. Activities of the head nurse, evening and night personnel,
11. Staff rounds, medical rounds,
12. Visiting hours, guest procedures and policies,
13. Nursing care plans, a guide for anecdotal records,
14. Sample stationery, where to find equipment, who fills out requisitions, number of copies needed, approval necessary and destination and
15. Daily reports, census reports and annual reports.

An efficient system of record keeping should be in effect and set up to reduce the time spent at the desk. Some of the records kept are the Kardex system for nursing care plans (continuity of care as well as comprehensive planning is an objective of such a system and a considerable amount of time can be saved when a good procedure is instituted and carried out), doctors' orders, patients' charts, time sheets, assignment records, interdepartmental transactions, requisitions, student records, statistics on nursing care hours and narcotic records and a great many more. A good filing system should be standardized throughout the hospital which will minimize time spent in locating materials.

Efficient planning, organizing and directing the resources within the unit will pay dividends not only to the head nurse but will be extremely useful to the staff.

In conclusion, the important functions of the head nurse in managing the nursing unit are three:

1. The head nurse must be a successful leader and manager; planning, organizing, directing, coördinating and controlling the human and non-human resources of the unit. 2. She must accept and be ready for the great responsibility of managing personnel, effectively utilizing this human power and coördinating the efforts of all personnel in improving patient care. 3. She must manage the resources within the unit for the best possible use for an efficient, orderly and safe environment as well as an environment free from tension and stress; must provide an efficient system of controls for greatest effectiveness.

It is the author's fervent hope that some of these ideas when interwoven with those of readers may set up a chain reaction of effective changes in the management of the nursing unit. ★

(ADVERTISEMENT)

Take a Close Look at Hospital Injectables

Reading time: 2½ minutes **Benefits: 12**

There is little doubt that disposable equipment has assumed great importance in the modern hospital. Certainly, no hospital administrator would dispute the fact that disposable items such as knife blades, blood lancets, urine collection bags, catheters, and enemas all help increase efficiency and, often, cut costs.

On the other hand, much can be said for equipment of a more permanent nature. Personnel have usually had experience with it. There's no need for constant re-ordering; the cupboard is rarely bare.

You can have both

The advantages of disposable and permanent equipment do not necessarily have to be separate and distinct. In the TUBEX® closed-system of injectables, for example, the best features and advantages of both are combined. The system comprises a durable, finely made syringe and a disposable cartridge (glass) and needle unit containing a pre-measured dose of medication.

Injection with TUBEX *simply requires that the proper pre-filled cartridge-needle unit be selected, inserted in the syringe, and aspirated. After the injection has been given, the cartridge-needle unit is discarded; the syringe is ready to use again . . . and again . . . and again . . .*

The benefits that the TUBEX system brings to hospital personnel, and the contributions that it makes to hospital efficiency and the welfare of patients, are impressive. Consider, if you will, the following examples.

1. Accurately measured dose assured
2. Danger of giving wrong drug reduced

Each sterile cartridge-needle unit contains an accurate, clearly labeled dose. Therefore, the nurse no longer must measure out doses as before—perhaps from an often-used, possibly contaminated multiple-dose vial. She runs little risk of administering an inaccurate dose or, worse yet, the wrong drug entirely. Obviously, the less chance for error the fewer the number of malpractice suits.

3. Efficiency of Central Supply increased
4. Breakage losses reduced

TUBEX cartridge-needle units are pre-sterilized; the needles pre-sharpened. This means that Central Supply can turn its attention to duties other than the time-consuming sterilization of syringes and the sharpening and sterilization of needles. It also means that breakage, which invariably accompanies these operations, and which raises the hospital's costs, is drastically reduced.

5. A source of hepatitis eliminated
6. Contact sensitization minimized

TUBEX cartridge-needle units serve for a single injection only. There can be no contaminated needles to transmit serum hepatitis or other diseases. Also, because there is virtually no chance for spillage, the nurse rarely comes into contact with drugs that might produce dermatitides or be absorbed to cause even more serious effects.

7. Inventory control simplified
8. Narcotic security tightened

The TUBEX system requires only two parts, half as many as the "conventional" system.

TUBEX System: cartridge-needle unit, syringe
Conventional System: plunger, barrel, needle, medication

There are fewer records to keep. Inventory control, therefore, is more accurate and efficient. As inventory control becomes more accurate, narcotic security automatically tightens.

9. Patients react more pleasantly to injections
10. Most commonly used drugs available

The most obvious direct benefit that the TUBEX system provides for the patient is a relatively painless injection, the result of a fresh, pre-sharpened, single-use needle. Since most common drugs—and many uncommon ones as well—are available in TUBEX form, the majority of hospital patients can benefit from the TUBEX system.

11. Accounting made more efficient
12. Billing made more accurate

Since each cartridge-needle unit contains a single, pre-measured dose, the amount of medication, including narcotics, that is given a patient is readily ascertainable. Hence, accounting is facilitated and the proper charges to the patient can be made accurately and easily.

In summary

As you can see, adoption of the TUBEX system can have far-reaching effects. Efficiency and morale of the staff are improved. Labor costs—currently about 70 cents of every dollar spent by the hospital—are markedly reduced. Accounting, billing, and inventory control are made more accurate. The risk of malpractice suits is mitigated. The well-being of patients is enhanced.

The TUBEX system can presently supply more than 75 per cent of injectables commonly administered in hospitals. And medications not yet available in TUBEX form can be administered by means of empty, sterile cartridge-needle units. Thus, the TUBEX system is capable of meeting every need for injectables.

The TUBEX system is already in wide use. To learn more about the many benefits that the TUBEX system can bring to *your* hospital, please see your Wyeth Territory Manager or write to Wyeth Laboratories, P.O. Box 8299, Philadelphia 1, Pa.

ST. ANNE'S HOME

(Begins on page 74)

therapy, guests' laundry, boiler room, main laundry, general store rooms, trunk storage, maintenance shops, receiving dock and staff garages.

The main dining room is subdivided into small areas for the use of 24 or 28 people by low space dividers again to provide an atmosphere cognizant of the personal dignity and individuality of the guest. Waitress service will be provided, and there will be four guests at each table. The decor and atmosphere will be that of a high class hotel dining room complete with table cloths and carpeting. The space dividers will be decorated with the flowers of the season. Plans have also been made for the installation of two fountains in the dining room and the use of birds and aquariums. These, to the aged, are signs of life and of hope, and will surely attract the interest of the guests, and again help to draw them into the activities of the Home.

The recreation room will also double as an auditorium with a portable stage and motion picture screen. It will be subdivided by movable game carts which will act as space dividers for card games, etc., and will have direct access to outside terraces and recreational areas.

The trunk storage area is a very important place in a home for the aged and, therefore, has been placed in the general area of the dining room and recreation room. It has been designed so that the guest can go to his trunk and take out some of his treasured possessions and change the items in his room at will. Trunks form a treasured link with the past and, therefore, have been made most accessible to the guest.

The guest laundry is another important morale builder in a home for the aged, for here the guest will find domestic size washers and dryers so that he or she can wash out a few things that they do not feel they should send to the main laundry.

Of course, the barber shop and beauty shop are a necessity in any institution for long-term care. At St. Ann's they are located directly off the elevator lobby on the ground floor to provide a hotel atmosphere.

There are two small stores on the ground floor for the disposition of articles of clothing and other things which are donated to the home. The prices will be extremely reasonable because the purpose is not to make money, but rather to provide an equitable arrangement for the distribution of such items—and to the ladies an opportunity to shop for something.

The site of the building is 23 acres of rolling land about three miles from downtown Rochester. It is on a bus line and is across the street from a large general hospital. It is about 500 feet from Rochester's new outer loop and will be easily available by bus or automobile from any part of the city of Rochester. This will enable the guests to keep in contact with the community and their families and should encourage the families to visit the guests frequently. Bus service will be available at the door and the guests will be able to go directly downtown on this service, passing several shopping areas on the route. The building will set back about 700 feet from the main street and will have as a back drop an existing woods, complete with a stream.

A year and a half has been devoted to researching and planning this building which should be under construction contract by March 15, 1960.

Patterns of Success

...that emerge from CCS fund raising campaigns. Although the final pattern may differ somewhat from campaign to campaign, the elements that make up the pattern remain the same. These elements are: *"the cause", the prospects, leadership, workers,* and *know-how.*

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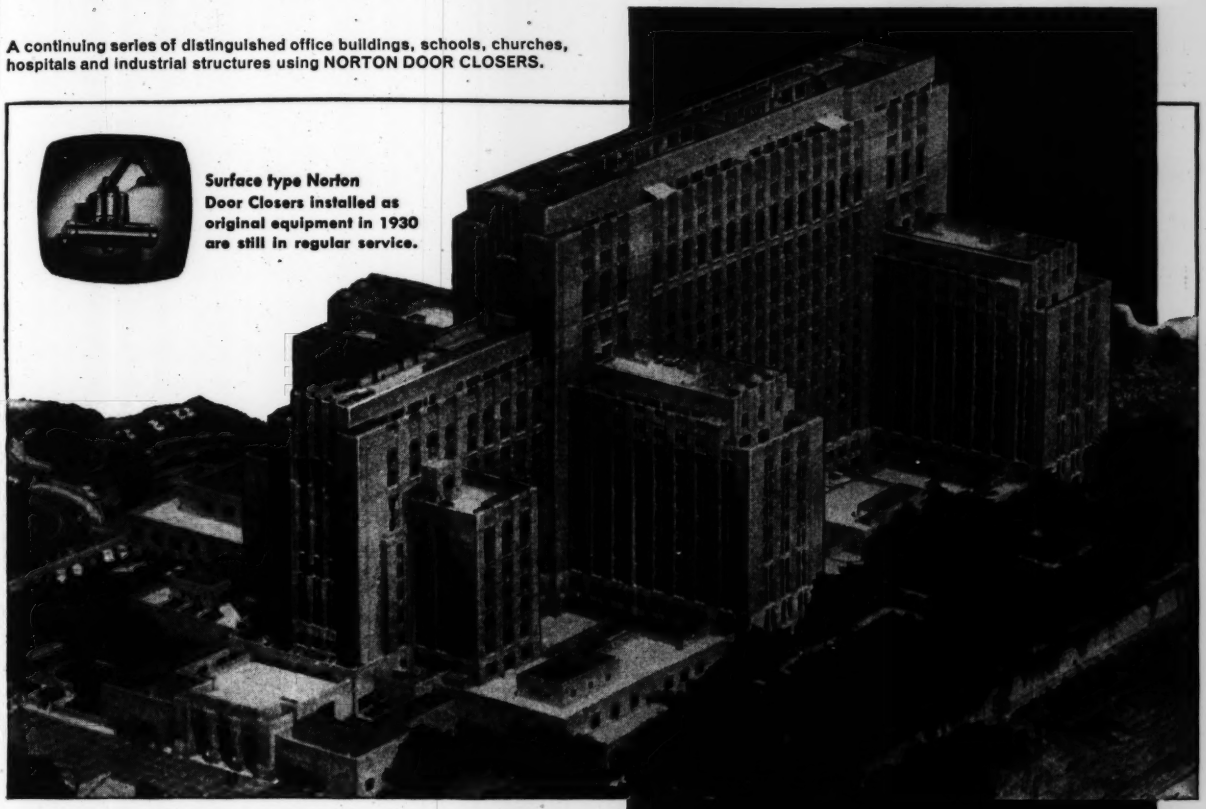

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Available with (A) regular arm or (B) holder arm . . . 4 sizes to meet all requirements

PEOPLE & PLACES

by **MARIE T. AUBUCHON**

Personnel Changes

■ WALTER OKA has been placed in charge of the blood bank, Good Samaritan Hospital, Cincinnati, Ohio.

■ MAJOR ERLAND D. KIDDIE, former chief medical statistician at Fort Carson U.S. Army Hospital, has been named administrative assistant at Penrose Hospital, Colorado Springs, Colo.

■ MISS BETTILOU PURRMAN has been named chief of the newly created occupational therapy section of the physical medicine department, St. Nicholas Hospital, Sheboygan, Wis.

■ HERBERT D. RODDE, Deerfield, Ill., has been named assistant administrator of St. Joseph-Lloyd Hospital, Menominee, Wis. **Sister Mary Alacoque,** is administrator.

■ MRS. PAMELA OATES has been named credit manager at St. Alexis Hospital, Cleveland, Ohio.

■ JOSEPH KELLEY has been appointed to direct the housekeeping department at St. Joseph Hospital, Fort Wayne, Ind.

■ MRS. MARGARET SILVOY has been appointed health nurse of St. Joseph Hospital School of Nursing, Fort Wayne, Ind.

■ MISS VIRGINIA A. GAFFEY has been named director of the school of anesthesia, Carney Hospital, Boston, Mass.

■ MISS ANNA SABARA has been appointed director of nursing at St. Anthony de Padua Hospital, Chicago, Ill. She was formerly an associate director of nursing education at Research Hospital, Kansas City, Mo.

■ THERESA NIEMEK MITCHELL has returned to St. Margaret's School of Nursing from a leave of absence for graduate study. Mrs. Mitchell is now instructor of medical and surgical nursing.

Honors and Appointments

■ CERTIFICATES of meritorious service were presented to doctors with 25 years of service at Little Company of Mary Hospital, Evergreen Park, Ill. They are **Dr. S. N. Saletta; Dr. W. G. Shurtz** and **Dr. C. P. Sullivan.** A posthumous award was made to the family of **Dr. Harold McGrath** who served the hospital for 24 years until his death in October, 1959.

■ DR. RALPH E. ADAMS has been awarded the Carl A. Erikson Fellowship in Hospital Administration at the University of Chicago.

■ MOTHER MARY CANDIDA, former administrator of St. Elizabeth Hospital, Houston, Tex., has been named Mother Provincial of the newly established U.S. Province of the Missionary Sisters of the Immaculate Conception. The 600 sisters staff 60 hospitals, schools, colleges and orphanages. The congregation is headed by **Mother Mary Veneranda,** Superior General. The motherhouse is in Paterson, N.J., at Immaculate Conception Convent.

■ ELTON TEKOLSTE has been appointed to the newly created full-time position of executive secretary for the Indiana Hospital Association, Indianapolis.

■ MOTHER MARY WILLIAM HAUG has been named Provincial of the St. Louis (Western) Province of the Sisters of Divine Providence. She is the former administrator of St. Elizabeth's Hospital, Granite City, Ill., and the sister of **Msgr. William F. Haug,** vice-chancellor of the Springfield, Ill., diocese and **Sister Mary Ann Haug,** novice mistress at the Divine Providence novitiate, Normandy, Mo. She succeeds Mother Mary Lucina who was transferred to Rome last fall to be secretary to the community's mother general.

■ ROBERT W. LANNAN, chairman of St. Mary's Hospital, Minneapolis, Minn., and **Richard T. Seidel,** member of the board were honored with Knighthood in the Order of St. Gregory by His Holiness Pope John XXIII.

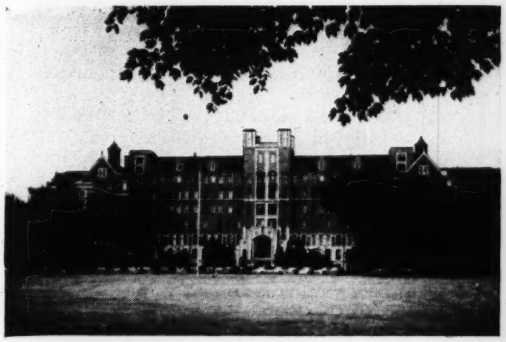
■ DR. GEORGE PINESS is the first physician to be elected president of St. Anne's Foundation, Los Angeles, Calif., since its establishment as a California non-profit organization in 1946. He heads the George Piness, M.D. Allergy Group of Beverly Hills and is internationally recognized as one of the world's foremost specialists who has trained more allergists than any single mentor.

■ DR. JOHN PAUL NORTH, Dallas, Tex., has been named director of the American College of Surgeons. He succeeds **Dr. Paul R. Hawley,** the director since March, 1950.

Jubilees and Anniversaries

■ SISTER MARY THOMASINE, O.S.F., recently celebrated her 85th birthday.

INTERMEDIATE WORKSHOP for improvement of schools of Medical Technology at St. Louis Jan. 25-29 brought back most of former students from previous basic course. The faculty of 24 and students numbering 92 represented 96 schools and 31 states.



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By LUELLA J. MORISON, R.N., M.A. Just published. 1960, 3rd edition, 384 pages, 8¼" x 10½", illustrated. Price, $4.75.

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COMMUNICATION FOR NURSES

No longer need the nurse master techniques alone—today she must also learn and apply principles that will meet the emotional, social and spiritual needs of the patient. Designed for "Professional Adjustments." "Nursing Arts" or "Communication" courses, this book helps students develop the communicative skills necessary to become an articulate and perceptive nurse. It also covers function in planning and giving nursing care in the hospital and in professional growth.

By FLORENCE K. LOCKERBY, A.B., M.A. 1958, 175 pages, 5½" x 8½", 5 illustrations. Price $3.75.

3rd Edition **McClain-Gragg**

SCIENTIFIC PRINCIPLES IN NURSING

Rearranged in a more logical teaching sequence, this newly released 3rd edition of SCIENTIFIC PRINCIPLES IN NURSING is a compact yet complete presentation of basic nursing principles. Written specifically for courses in "Fundamentals of Nursing," "Nursing Arts" or other basic courses, this text fully develops the idea of total nursing care of the patient and uses procedures only where they classify certain principles for the student. This book is also meaningfully illustrated with many photographs specially posed to teach a specific principle or procedure.

By M. ESTER McCLAIN, R.N., B.S., M.S. and SHIRLEY HAWKE GRAGG, R.N., B.S.N. 1958, 3rd edition, 535 pages, 5½" x 8½", illustrated. Price, $4.50.

2nd Edition **Price**

A HANDBOOK AND CHARTING MANUAL FOR STUDENT NURSES

Originally published as a charting handbook, the 2nd edition of this highly useful handbook has been revised to give the student the latest methods and concepts of charting. The new content can provide valuable assistance to instructors in all nursing courses in which emphasis is placed on mathematics, spelling, vocabulary and reading ability, and in which personal attitudes and relationships are stressed. This book can be used to help qualify prospective students for admission to schools of nursing and as a study aid for the student prior to admission. All of the tests and lessons can be self administered and self graded.

By ALICE L. PRICE, R.N., M.A. 1958, 2nd edition, 316 pages, 8½" x 11", illustrated. Price, $4.50.

Gladly sent to teachers for consideration as texts

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Sister, who is dean of hospital administrators in the Pittsburgh district, recently announced her retirement.

■ SISTER MARY JOELLA, O.S.F., St. Joseph's Hospital, Reading, Pa., recently celebrated her silver jubilee.

Bon Voyage

■ DR. ANTHONY M. OPISSO, Columbia Falls, Mont., has abandoned a successful practice to work among the poor on the island of Dominica in the British West Indies. While waiting for the necessary clearance to go to the West Indian island, he accumulated more than a ton of medical supplies which he will take with him. He will work in a 700-bed hospital operated by three sisters on the island. Dr. Opisso is a gradutae of Loyola University medical school.

■ THREE GRADUATES OF ST. FRANCIS Hospital School of Nursing, Trenton, N.J., have departed for the foreign medical missions. They are **Sister Mary Stella, S.C.M.M.,** who has been assigned to Nuestra Senora de Coromoto Hospital, Maracaibo, Venezuela; **Sister Mary Jane** and **Sister Mary Celine, S.C.M.M.,** who have been assigned to Holy Family Hospital, Rawalpindi, Pakistan.

R.I.P.

■ FATHER PETER P. GARAHY, superior of the Columban Fathers Mission Center, West Chester, Pa., died of lung cancer in January.

■ SISTER MARY ADOLPHA, S.S.M., a dietitian at St. Francis Hospital, Wichita, Kan., for almost 30 years, died recently.

■ DR. JAMES V. BEYNON, 75, former chief of staff at St. Anthony Hospital, Rockford, Ill., died after a long illness.

■ SISTER MIRIAM ANTHONY, M.S.C., died recently at St. Joseph Hospital, New York. Her missions in the past included St. Lawrence Hospital(now Columbus Hospital), the Catholic Protectory, St. Vincent's Hospital and 26 years at the New York Foundling Hospital, her last assignment prior to her retirement in 1958.

■ SISTER MARY INNOCENTIA, 78, and **Sister Mary Isabella,** 81, Sisters of St. Mary, died recently at St. Mary of the Angels Motherhouse, Richmond

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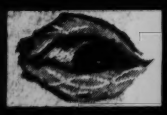

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Heights, Mo. Sister Isabella had been a nurse at St. Mary's Infirmary and at St. Mary's Hospital, Jefferson City and Mount St. Rose Hospital, St. Louis. She had been in semi-retirement for 15 years. Until the order stopped begging, Sister Innocentia's duties had included begging at wholesale houses and butcher shops for food for the patients and the nuns at St. Mary's Infirmary. After 1930 she had engaged in domestic duties around the motherhouse.

■ DR. JOSEPH M. BARKER, 49, heart specialist, died recently. He was a graduate of Georgetown University Medical School.

■ SISTER EUGENIA, D.C., 52, died recently at Seton Hospital, Austin, Tex. She once served as director of the school of nursing of Sisters' Hospital, St. Joseph, Mo.

■ SISTER MARY ISABELLE, 48, of the Sisters of Charity of the Incarnate Word, died recently in Houston, Tex. She was the sister of **Sister Mary Christine,** administrator of St. Joseph Hospital, Houston.

■ BROTHER MARTIN MOLYNEAUX, C.F.A., director of Alexian Brothers Hospital 20th Century Fund, died at Alexian Brothers Hospital, St. Louis. Although confined to a wheelchair for a number of years, Brother Martin remained active in the hospital's administrative staff until his sudden death, attributed to a heart ailment. He came to St. Louis in 1956 to work with the hospital's advisory board in its fund-raising program for a $1,600,000 expansion completed last year.

■ SISTER MARY LAWRENCE, C.S.J., 82, died recently at Ponca City Hospital, Ponca City, Okla., where she had served as administrator for 20 years. She had been the first administrator of the hospital when it was turned over to the Sisters of St. Joseph.

■ SISTER MARY CELESTE FRANCIS, O.S.F., died recently at St. Francis Hospital, Trenton, N.J. She was a medical technician.

Places

■ A NEW SERVICE is available at the Joseph P. Kennedy Jr., Memorial Hospital, Brighton, Mass., owned and operated by the Franciscan Missionaries of Mary. A short-term evalua-

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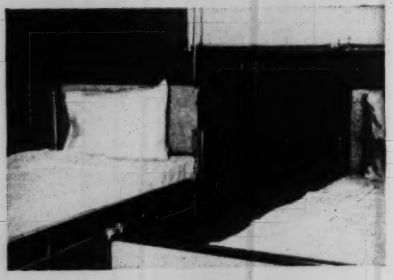

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tion admission, the only program of its kind in the New England area, has been in operation since the first of the year. Patients are admitted to the hospital for a complete diagnostic study and work-up lasting from five to 10 days. Aiming toward a shorter hospitalization for pediatric rehabilitation patients, the evaluation admission enables the hospital team and consultants to set up a program of total care and treatment prior to the patient's actual admission for intensive rehabilitation services, or for a home management program with follow-up in ambulatory facilities. The new program, with its goal of shorter hospitalization and closer family relations, is another step forward in the field of pediatric rehabilitation.

■ PROVIDENCE HOSPITAL, Sandusky, Ohio, has launched a campaign for over a million dollars to finance a broad expansion and modernization campaign. The expansion will include construction of dormitory facilities for student nurses of the Providence School of Nursing, a new structure to house classrooms and other educational facilities, the construction of a modern two-story wing for rehabilitation and occupational therapy facilities and 94 beds for the use of extended illness patients. Total cost will be $1,680,708. **Sister Mary Lucia, O.S.F.,** is administrator.

■ THE NEW CASTLE, Pa. *News* paid editorial tribute to New Castle Hospital, operated by the Sisters of St. Francis, during their expansion campaign for their demonstrations of true brotherhood. Campaign kickoff dinner was held in the First Presbyterian Church and the general chairman in charge of the campaign is **Louis Sandler,** a Jew.

■ ST. MARGARET HOSPITAL, Hammond, Ill., recently received a federal grant of $12,000 for cancer treatment equipment. Construction of a treatment room is under way in the basement of the new hospital wing.

■ SISTER CLARE DOLORES, S.C., administrator of St. Vincent's Hospital, Mountclair, N.J., has announced the establishment of a completely equipped radio isotope department and the appointment of **Dr. Martin Lowenthal** to head it.

■ ST. MARY'S HOSPITAL, Jefferson City, Mo., has become a coöperating eye bank substation of the Washington University School of Medicine eye bank program, it was announced by **Sister Eugene Marie, S.S.M.,** hospital administrator.

■ PROVIDENCE HOSPITAL, Kansas City, Kan., operated by the Sisters of Charity of Leavenworth, is celebrating its 40th year.

■ BETHANIA HOSPITAL, Wichita Falls, Tex., is celebrating its 25th anniversary. The Sisters of the Holy Family of Nazareth who operate the hospital will celebrate their diamond jubilee of work in the U.S. in July.

■ BISHOP CHARLES H. HELMSING of the Springfield-Cape Girardeau Diocese blessed the new wing of St. John's Hospital, Springfield, Mo., recently. The addition will serve both as a psychiatric and surgical-medical wing.

■ ST. MARY OF NAZARETH HOSPITAL, Chicago, Ill., will establish its own printing department according to **Sister Mary Edelburg, C.S.F.N.,** administrator.

■ THE PSYCHIATRIC treatment center at St. Joseph's Hospital, Fort Worth, Tex., has reopened its four maximum-security rooms and 12 bed-ward.

■ THE NEW WING of St. Francis Hospital, Escanaba, Mich., was dedicated recently. The wing will house most of the hospital's service departments.

■ THE NEW $3,500,000 LITTLE COMPANY OF MARY HOSPITAL in Torrance, Calif., will be the first Catholic hospital west of the Mississippi to be operated by the Sisters of the Little Company of Mary. Formal dedication ceremonies were held recently with **His Eminence James Francis Cardinal McIntyre** officiating. The hospital has a fully equipped emergency department which will remain open and fully staffed 24 hours a day, x-ray department, deep therapy, cystoscopic and physical therapy departments, complete pediatrics department, four operating rooms, recovery room, obstetrics and nursery department. The Knights of Columbus of Redondo Beach have donated two statues of the Maternal Heart of Mary, life size and sculptured in Italy of white Cararra marble. One will be located in the hospital lobby and the other in front of the building, according to **Mother Patricia.** ★

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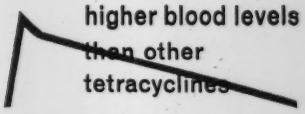

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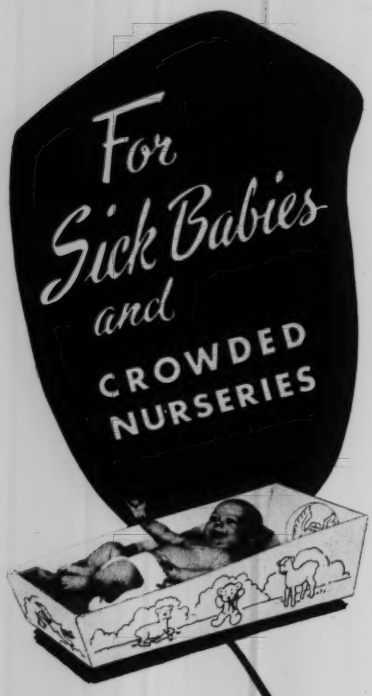

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PURCHASING

J. Fred Knight

(Begins on page 70)

number, with the further statement that "or equal" items will receive consideration, will sometimes produce quotations on an alternate or a substitute item that might very well be just as good—even better; and in many cases cheaper for the hospital. If specifications, quantities and items can be agreed upon, keeping in mind all of the factors that must be coördinated, including the experience and knowledge of the department, it should not be too difficult to prepare bids for the purpose of ordering the equipment.

One factor that should not be overlooked is the matter of value analysis. Very recently Stanley Hopper of the Purchasing Division of Zenith Radio explained how Zenith, through years of value analysis, has worked out a program in order to get the best item at the right price. The combined activities and energies of five men in the Zenith organization have saved the company more than two million dollars per year in procurement by the application of value analysis to the entire purchasing program.

The purchasing officer should realize that his job, sometimes, is to buy—at other times it is *not* to buy; and in many areas it is necessary to do much product research and departmental checking before this decision can be reached.

The questions that should be asked at this level are: 1. What is the item or product going to be used for? 2. What will it do? 3. Will it do these things better, cheaper or faster than any other product? 4. Will it do these things with less manpower than the other products, or competitive items?

With these questions answered and an analysis made as mentioned above, the purchasing officer may be able to establish certain standards and work out a standardization program on similar and allied items that are to be used throughout the hospital.

With a composite review and in light of known space and funds available, the purchasing agent should be about ready to re-edit and tabulate the lists and make purchases. However, at this point it should be kept in mind that most professional people are not cost-conscious and some startling economies can be effected in many areas simply by getting top administration to establish a standard or a policy beyond which the purchasing officer should not go.

For instance, certain areas do not need either drapes or rugs. Standard lines of office furniture should be ample in quality and stability to meet the needs of all ordinary personnel. Few areas can justify the use of electric typewriters—particularly the proportional spacing models; and every department does not need its own ditto, mimeographic, multigraph or other reproducing machinery. Perhaps these admonitions may sound stern, but I am assuming that the funds for your hospital, the same as those for ours, have to come from somebody's pocketbook. The donors and the people who raise the funds are entitled to see the money used intelligently as well as economically.

The stewardship of these funds may determine whether or not other funds will be forthcoming from the same donors or sources. Having reduced the list, if possible, to spartan proportions, perhaps it would be well again to look and see that it does NOT include luxury items, specially-made pieces of equipment and items that can only be operated by highly trained, skilled technical people. Now, put all chairs, tables, desks and office furniture on one list. Reduce the styles and models to the minimum number. Ask for samples from two or three reputable manufacturers if it seems necessary to effect a final decision. Take a long look at this particular list of furniture and ask: 1. Can this equipment be interchanged with the equipment in other rooms? 2. How will it affect the decor of the area and the efficiency of the operator or user?

Now send out for bids. Bidding practices may differ. We prefer the use of sealed bids with extensive specifications, with an outline of the conditions under which the equipment will be accepted, the terms of delivery, etc.

A face sheet simplifying and outlining these conditions was developed and has been used in the purchase of more than $300,000 worth of such equipment in a new hospital addition on our campus. The practice mentioned may be used for various groupings and classes of equipment—combining quantities for various departments wherever possible and grouping items that will come from the respective classifications of vendors.

(Concluded on page 168)

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POSITIVE STERILIZATION—Steam touches all surfaces of the syringes and needles directly.

THOROUGHLY TESTED AND PROVED—thousands of Steri-files in use.

PORTABLE—Carry the Steri-file to wherever sterile syringes and needles are needed.

For 2 cc—5 cc—10 cc syringes—needles of all sizes.

WRITE FOR FULL DETAILS.

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HOSPITAL_____

ADDRESS_____

CITY_____ STATE_____

DEBS Hospital Supplies, Inc.
5990 NORTHWEST HIGHWAY, CHICAGO 31, ILL.

(Begins on page 95)

In concluding his recommendation, the Secretary stated the proposed legislation:

> "will contribute to strengthening the roll of institutions involved in these (research) programs and provide for a greater sharing of responsibility for the Administration and support of research grant programs administered by the Public Health Service."

On Feb. 10, 1960 Mr. Harris introduced H.R.10341, which was referred to the Committee on Interstate and Foreign Commerce. The text of the Bill follows:

> To amend the Public Health Service Act to authorize grants-in-aid to universities, hospitals, laboratories, and other public or nonprofit institutions to strengthen their programs of research and research training in sciences related to health.
>
> *Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That section 301(d) of the Public Health Service Act, as amended (42 U.S.C. 241(d), is amended by adding after the semicolon at the end thereof "and make, upon recommendation of the National Advisory Health Council, grants-in-aid to public or nonprofit universities, hospitals, laboratories, and other institutions for the general support of their research and research training programs: *Provided,* That such uniform percentage, not to exceed 15 per centum, as the Surgeon General may determine, of the amounts provided for grants for research projects for any fiscal year through the appropriations for the National Institutes of Health may be transferred from such appropriations to a separate account to be available for such research and research training program grants-in-aid for such fiscal year;."

The Forand Bill continues to draw a substantial amount of attention. This bill, which was introduced in 1959, would amend the Social Security Act and the Internal Revenue Code to provide insurance against the costs of hospital, nursing home and surgical service for persons eligible for Old Age and Survivors Insurance benefits. The money to underwrite this broad program would be derived from an increase in the Social Security tax. Hearings have been concluded on the bill and it is estimated the Ways and Means Committee of the House will take action this month.

Senator Kennedy and Senator Hart have introduced a similar measure in the Senate. Actually, it is broader than the Forand legislation. It would amend the Social Security Act to provide insurance against the costs of hospital, nursing home, home nursing service and diagnostic outpatient hospital service for persons eligible for Old Age and Survivors Insurance benefits. It is too early to speculate intelligently on the probable outcome of this proposed legislation. There is strong opposition from the A.M.A. and other groups; however, some groups which initially opposed the Forand concept are moderating their positions.

In the meantime, hearings conducted by the McNamara subcommittee investigating problems of the aged have produced formidable statistics demonstrating the need for some type of medical assistance for the aged. The accumulated statistics demonstrating a need, plus the fact that this is an election year, will obviously work in favor of the passage of this legislation. As action develops on this legislation, it will be reported in this column. ★

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can provide either CONTINUOUS or INTERMITENT suction

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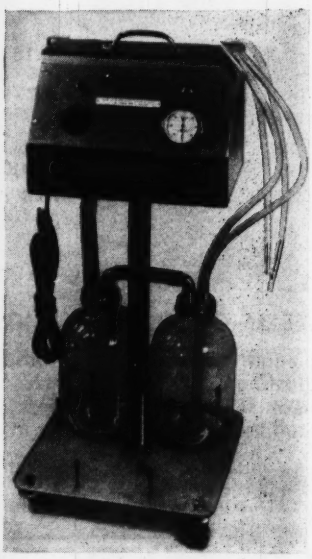

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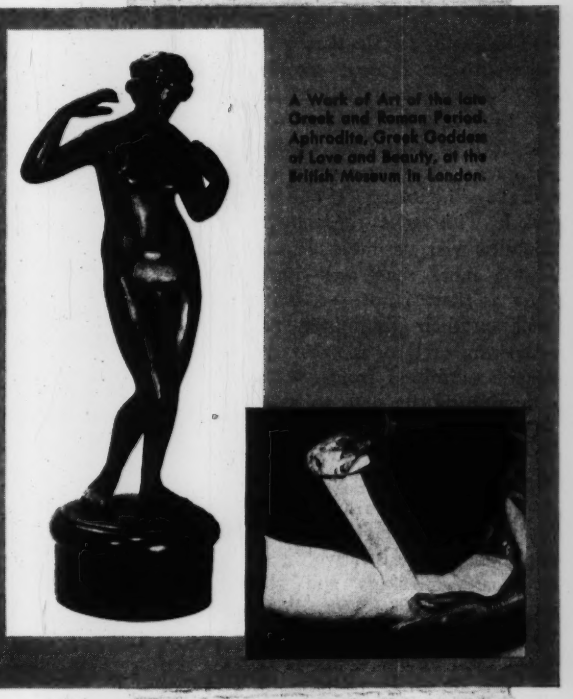

A Work of Art of the late Greek and Roman Period. Aphrodite, Greek Goddess of Love and Beauty, at the British Museum in London.

With STUCCA Plaster of Paris bandage you create a work of art . . . a perfect cast . . . with speed, strength, fidelity — assuring firm support and immobilization for every type of fracture, every time.

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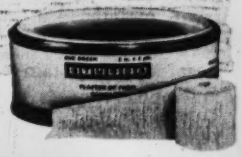

For complete data and FREE sample sufficient for your own testing purposes, write today.

ACME STUCCA

ACME COTTON PRODUCTS CO., INC.
245 FIFTH AVENUE, NEW YORK 16, NEW YORK

(Begins on page 70)

In reviewing lists and before issuing them for bids a purchasing agent may wish to discuss certain classes of equipment with his favorite source. If he does, he exposes himself to the criticism of having given his source an inside track or a preview, even though his intent may have been perfectly ethical and honorable. If one wishes to consult with sales representatives it would be wise, desirable and ethical to include more than one—perhaps as many as three items—or, better still, to obtain their preliminary proposals in writing and to ask that the samples be submitted from all three for evaluation by the staff.

One technique in buying hospital room furniture is to have each of two or three suppliers set up a complete hospital room in an area marked for this purpose. After the staff—professional and administrative, as well as the board members and all other proper personnel—have had an opportunity to make their comments and the equipment has been evaluated, it will be quite simple to limit the specification to the desired items and to invite sealed competitive bids.

Perhaps it would be well to mention here the advantages or disadvantages of the rental of capital items. There are certain advantages which must be evaluated by the purchasing officer in keeping with the conditions and finances of his own organization. Rental on contract, with option to buy, including the condition that the rental may be applied on the purchase, is sometimes desirable. The reasons may include the following:

1. The hospital gets an opportunity to test the item in actual use without committing to purchase.

2. Extensive capital outlay is avoided.

3. If the rental agreement is properly drawn, maintenance and service costs can be avoided.

4. Hospitals can obtain equipment to meet temporary needs or problems —seasonal or otherwise—without purchase.

5. Operating costs can be positively determined.

6. There is no need to stock repair parts.

7. There is no problem of disposal or replacement.

8. The inclusion of licenses, insurance, etc. is customary on car and truck rental contracts.

9. In most cases the hospital will obtain a current or the latest model.

There is another side of the picture and it must be remembered the supplier, manufacturer, agent or dealer is in business to make money regardless of any gimmick or sales pitch he may use. It is his intention to make a profit on the transaction. Any purchasing agent about to make such a transaction should look long and hard to be certain that he is not establishing a policy or embarking on a voyage from which it may be difficult to return. In a word, if there is a profit in it for the supplier or renter one might be able, by astute business management, to save part of that by purchase.

The use of consultants—engineering firms and engineers from sales organizations or suppliers to do drawings, specifications and assist in the development of proposals—can be very helpful. One may approach this problem much as one would the employment of an architect. Examples of jobs or projects on which this has been used in our organization are:

1. Laboratory furniture—that is, case goods such as island base benches, sinks, fume hoods, storage cabinets, etc., either wood or steel.

2. Kitchen equipment or cafeteria lines—remember that stainless steel jobs require careful engineering and specifications if they are to be satisfactory. We have paid a seven per cent fee on kitchen jobs.

3. Large installations of animal cages in the research laboratories. This work we have had done on a fixed-fee basis.

4. Specially designed and fabricated items can be engineered for a fixed fee or a per diem.

5. Laboratory furniture: Our program has been to work out a per diem or percentage fee for the designer and engineer services, with the understanding that the complete drawings are prepared in our organization's name with our identifying card, to be supplied with detailed specifications.

After these are reviewed and approved by the department head, administration and engineers, they are submitted to more than one bidder to be sure that they are non-exclusive and are truly competitive. Then they are offered for bids, (as indicated in the procedure outlined earlier) with some assurance that we will get truly competitive figures. Obviously, the low bidder is required to submit complete shop and mechanical drawings to complement the proposal and is required to provide performance bonds to insure completion of the job in accordance with a signed agreement. In this way many heavy items of equipment can be bought on an "F.O.B. delivered and set-in-place" basis for the final connections by the proper building trades.

All of this must be well arranged in advance and stipulated in both the general and sub-contracts in order to avoid difficulty and friction between the equipment supplier and the contractor. Contracts for equipment awarded on this basis insure departmental satisfaction with the selection and save considerable money in profits paid to general or subcontractors. It involves a lot of work and the architect will not always be happy about this. However, if the hospital staff is determined and willing to work hard on the details of this equipment—and the negotiations —the saving will more than justify the extra work. Several things are necessary: 1. Complete contract documents. 2. Accurate and *approved* shop and mechanical drawings. 3. Follow-up to be certain that time schedules and specifications are met.

All of this, and the checking of performance bonds and the schedules of payment, will be the hospital's responsibility.

In all such bid documents we have included a clause or a paragraph on our bids which indicates delivery and installation as a requirement that "the bidder must visit the site and familiarize himself completely with all of the conditions of delivery and installation." No exceptions will be allowed, nor will any extras be paid because of the ignorance of the bidder or because of his failure to fulfill this condition.

If a purchasing agent expects to be treated like a professional, he MUST ACT LIKE ONE. Association with others, visiting the departments in his own hospital, as well as those in other organizations, will be of help in attaining his goal. One of the most impressive examples of dedication is Dr. Tom Dooley who, in returning to Laos —to his hospital there which he calls "The Edge of Tomorrow," said: "I have promises to keep and miles to go before I sleep." As Don McNeil often says: "Each in his own words, each in his own way."

Let these reflect the true dedication of every purchasing agent. ★

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Gardner-Murphy
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Scalp-Vein
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by
RANFAC

Catalog #SG-MD

The Gardner–Murphy outfit was especially developed, through RANFAC research, for constant intravenous therapy for infants. The needle has a short bevel and is attached to the hub by a special vinyl catheter. This catheter is non-toxic and produces no reaction when it comes in contact with tissue. The needle is easily inserted into the scalp vein and immobilized against the scalp with adhesive tape or plaster of paris strips. The Gardner–Murphy unit can be sterilized, by autoclaving, in the envelope in which it is packaged. The Gardner–Murphy outfit is available in 25, 24, 23, 22, 20 and 18 G.

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NEW SUPPLIES AND EQUIPMENT

Blood Bank Calendars Available

ABBOTT LABORATORIES has made available to all U.S. hospitals and commercial blood banks, a specially prepared Blood Bank Calendar in attractive colors.

Suitable for wall hanging, the Calendar gives the 21-day expiration date for blood drawn on each day of 1960. It is suggested that it be hung near the place for labeling of blood containers. The Calendar also contains sketches and descriptions of Abbott blood collection and administration equipment.

Hospitals or blood banks may obtain copies by contacting their Abbott representative or by writing to:

Abbott Laboratories
Professional Services
North Chicago, Ill.

Air Shields Manufacturing Rescue Unit in U.S.

AIR-SHIELDS, INC., manufacturers of the Isolette® Infant Incubator and other specialized hospital equipment, announces that AMBU Rescue Breathing Equipment is now being manufactured at the firm's Hatboro, Pa., plant. Although distributed for the past year by Air-Shields, Inc., the AMBU kit was formerly manufactured in Denmark, where it was designed. The equipment is functionally unchanged, but slight modifications in the suction pump permit easier cleaning of the trap bottle and better leverage for any operator.

The AMBU kit includes a hand-operated resuscitator and a foot-operated suction pump in a plastic carrying case. It has gained wide acceptance here and abroad. Lightweight, sturdy and easily operated, the equipment can be used by virtually anyone, anywhere, without time-wasting set-up or need for electricity or compressed gases. Consisting of a face mask, unique self-inflating bag and non-rebreathing valve, resuscitator delivers adequate volumes of air with the first squeeze of the bag. The foot-operated suction pump delivers intermittent partial vacuum for fast clearing of the airway.

AMBU Rescue Unit

AMBU is offered as a complete resuscitation-section unit, but either element may be purchased separately through:

Air-Shields, Inc.
Hatboro, Pa.

New Machine Permits Desk-top Copying

A COMPACT, LIGHTWEIGHT "Thermo-Fax" copying machine, designed for personal copying use in multiple office locations, has been announced by Minnesota Mining and Mfg. Co. Styled for desk-top use, the "Courier" copying machine operates on the same completely dry, all-electric copying principle as the other three models of "Thermo-Fax" copying products now available. It weighs only 25 pounds and is operated by a single control. It measures 14½ inches wide, by 12½ inches deep, by 4½ inches high and sells for $199.

Although designed to accommodate a new bond-weight white copy paper developed recently by the firm, any one of seven colored or special copy papers can be used.

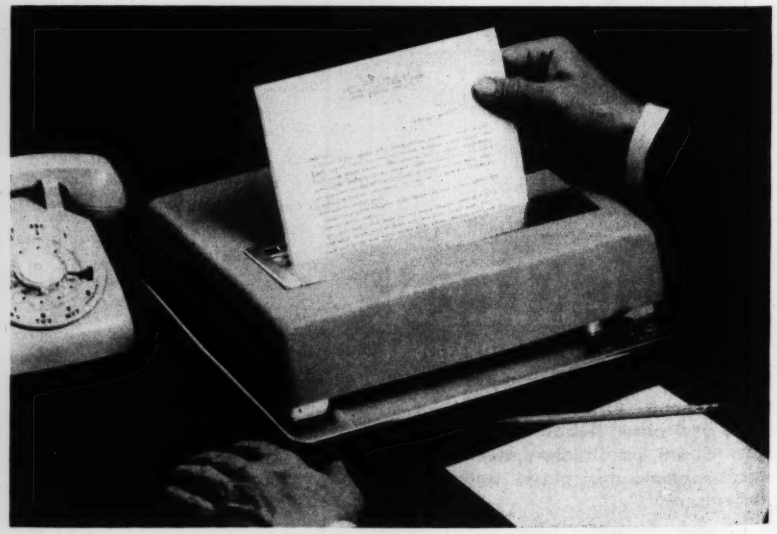
More information on the compact "Courier" copying machine can be obtained by writing:

3M Company, Dept. S9-515
900 Bush Avenue
St. Paul 6, Minn.

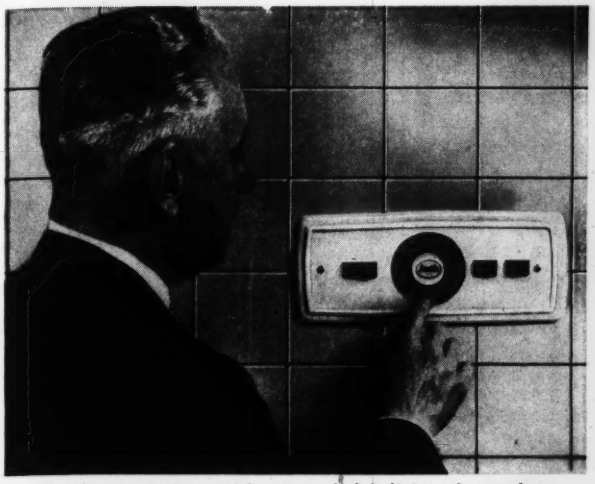
Simmons Trapeze Bar Called Patient Helper

SIMMONS' newly-redesigned Trapeze Bar now features an exclusive pivoting feature that enables the entire bar to be swung off at a 45-degree angle. Patients may thus use the bar as an aid in helping them get in and out of bed. Easily installed on all standard 3/0 hospital beds, Simmons' Trapeze adjusts to fit the height of the head and panel.

The Plastisol-covered Trapeze Bar hangs on a link chain, making it adjustable to any height and a locking arrangement keeps the Bar locked firmly in any position. Directly over the pa-



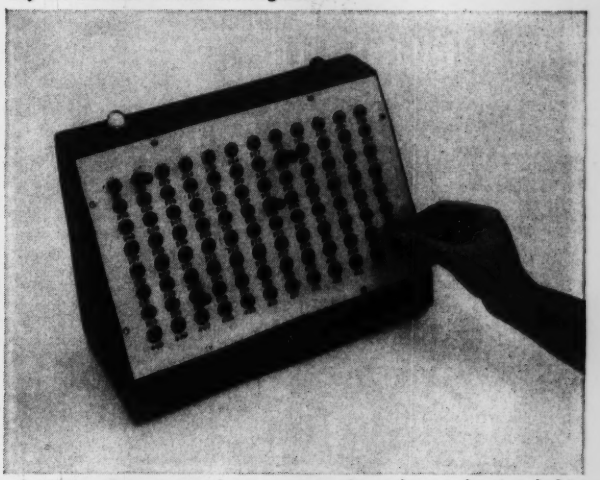
3M Thermo-fax Desk-top Copying Machine



▲ *Doctors—entering and leaving—dial 3-digit code numbers on small Dial-Registers placed at convenient locations—then press the IN or OUT button.*

▲ *Their IN-OUT status is transmitted by electrical impulses to the control center. There the information is stored for release to any IN-Former which interrogates it.*

▲ *IN-Formers are used by the telephone operator and others to check any doctors' IN-OUT status by dialing his code number. Colored lights reveal his status.*



▲ *When the operator has a message for a doctor she signals him through a plugboard. This flashes a light signal on all Dial-Registers as he dials himself IN or OUT.*

"DIAL-IN"

—*the Best Doctors' In-and-Out Register System for Large Hospitals*

This unique new staff register system is really a boon to large hospitals. When a doctor is urgently needed much time can be saved—perhaps a life— by knowing immediately and reliably whether or not the doctor is in the hospital. In large-staff hospitals with a number of entrances—or a number of buildings—the problem of registering the coming and going of doctors has defied a satisfactory solution. Up to now conventional register systems have required too much space; too much installation expense; too much inconvenience and time-loss to doctors and hospital personnel. Now, the Auth "Dial-IN" system eliminates these obstacles and makes it possible for large-staff hospitals to know who is in within a few seconds—and it does this conveniently for everyone and at reasonable cost.

The "Dial-IN" System and other types of doctors' in-and-out register systems; nurses' call systems; and doctors' paging systems—all designed to increase the efficiency of your hospital —are manufactured by AUTH. A representative is ready to discuss them with you. No obligation, of course.

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tient, it is used to adjust weight or as an exercise bar. When not in use, the Trapeze can be swung completely out of the patient's way. Stops prevent it from hitting walls.

Simmons Co.
Merchandise Mart Plaza
Chicago 54, Ill.

Picker X-Ray Announces Scintillation Scanner

A LOW-COST scintillation scanner that provides highly defined scans while subjecting the patient to smaller doses of radiation has been announced by Picker X-Ray Corporation, a leading maker of radiation and x-ray equipment. The Picker Cliniscanner has three unusual features that enable it to produce more clearly defined scans. A contrast circuit, Picker said, makes it possible to emphasize small relative differences in radioisotope concentration and to minimize the effect of background radiation on the scan. Reading of scattered radiation is eliminated by a pulse-height analyzer that records only the peak energy of the selected isotope. And, finally, "halo" is eliminated by a three-inch lead detector shield, which also contributes to reducing background and improving collimation, according to the company announcement.

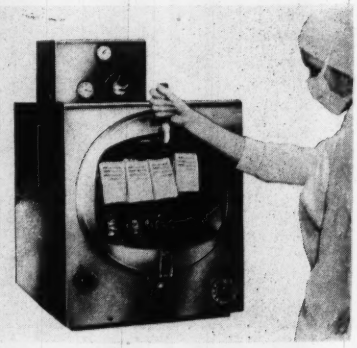
The scanner may also be used for uptake measurements, with the use of a flat field collimator.

Picker X-Ray Corp.
25 South Broadway
White Plains, N.Y.

Formula Help Offered Small Hospitals

A LOW-COST infant formula sterilizer has been developed for the small nursery by American Sterilizer Co., with all operating and safety features of larger models. With ample capacity for service to eight bassinets, Model 832 processes 32 four or eight-ounce bottles, with a forget-proof time and temperature cycling operation through simply-set automatic controls.

Treating this new formula sterilizer as the basic unit, the company is prepared to offer room plans to convert limited available space into a complete infant formula room with the service and operating characteristics of equipment previously available only for larger hospital installations.



A.S. Formula Sterilizer

Detailed literature is available from the manufacturers upon request for Brochure SC-319.

American Sterilizer Co.
Erie, Pa.

Kenalog Available In Spray Can

E. R. SQUIBB & SONS announces the availability of Kenalog (Squibb's triamcinolone acetonide) in aerosol spray form. A clinically superior topical corticosteroid, Kenalog in spray form provides a fresh approach to dermatologic therapy.

Kenalog Spray provides potent anti-

The accuracy and performance of the Brown Electro-Dermatome can only be assured when genuine Zimmer Dermatome Blades are used. These blades, bearing the Zimmer Ⓩ trademark, are precision-ground to maintain exacting skin-graft thicknesses. Each undergoes rigid quality control inspection.

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inflammatory, antiallergic and antipruritic relief, particularly in patients with acute, exudative lesions or those involving extensive hairy and hard-to-reach areas. It is well tolerated and works often where other topical steroids fail. It is available from Squibb in 50 and 150 gm. containers of 3.3 and 10 mg. triamcinolone acetonide respectively.

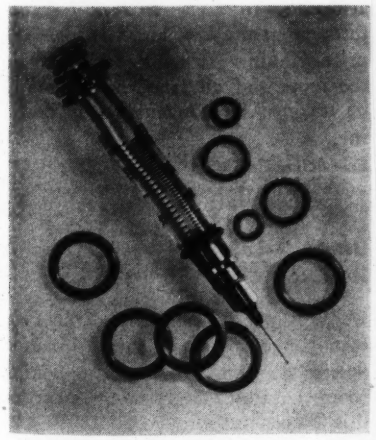
Squibb Division
Olin Mathieson Chemical Corp.
745 Fifth Avenue
New York 22, N.Y.

B-D Offers Color-Ident Rings

COLORED PLASTIC identification rings are being marketed by Becton, Dickinson and Co. to facilitate identification of certain equipment within hospitals, laboratories and research installations. The rings, called Colo-Ring, are intended for use on hypodermic units, for instruments used for dispensing radioactive materials and for identification of different patients, wards or diseases in a hospital.

The Colo-Ring group is marketed as a further step in Becton, Dickinson's program designed to advance the use of a standardized color-coding system by hospitals and research facilities.

Colo-Ring is available in small, medium and large sizes in red, blue, black and yellow. The small size is for use on needle hubs, 1 cc. syringe barrels and 2 cc. syringe plungers. The medium size is used for 2 cc. barrels, 5



B-D Colo-Rings

cc. and 10 cc. plungers. The large size is used for 5 cc., 10 cc. and 20 cc. barrels and 20 cc. plungers. The rings can be sterilized.

Becton, Dickinson & Co.
Rutherford, N.J.

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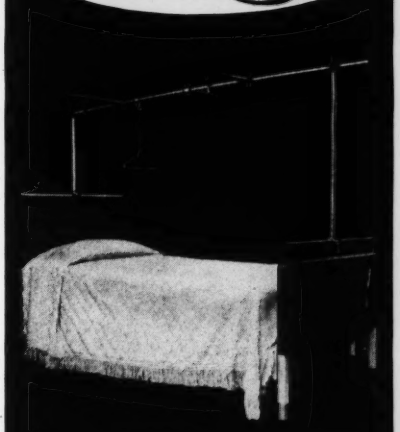
DePuy



NO CLAMPING REQUIRED!

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TRACTION FRAME

Designed to fit the modern variable height beds—*any make, any model*—without clamps. This outstanding new frame can be set up in seconds by one nurse. Support bars fit down into IV holes in the four corner posts of bed. *No clamping required.* No possibility of marring bed ends. Constructed of octagonal, no-slip aluminum alloy tubing for greatest strength with lightest possible weight—*only 22 lbs.* Accommodates all types of traction apparatus. No-slip design stops aggravating clamp slippage. *No. 748, complete with three abduction arms equipped with pulley and clamp, and trapeze assembly, $75.00.* (Specify make and model of bed when ordering.) Double-End Traction Bar, Side Arm Traction Bars, and extra interchangeable parts available.

Since 1895--the Standard of Quality
Write FOR COMPLETE CATALOG!

DePuy Manufacturing Co., Inc.
WARSAW, INDIANA

Frick Markets Hot Food Unit

THE NEW G 4 (KC) Special Hot Food Unit from W. H. Frick, Inc., facilitates dining service in any area where an electrical outlet is available. Food is kept hot and ready for service in areas away from the central kitchen. Constructed with a stainless steel compartment, stainless steel piano hinged drop doors on each side and removable electric heating element, the unit has a capacity of 54 10-inch plates and covers. The over-all length is 36", width is 25¼", height is 42". It is available with chromium plate frame, drop push-pull handles, strip bumpers, rotary ball bearing bumpers on non-marking rubber and super duty casters for loads up to 700 pounds. For additional information write to:

W. H. Frick, Inc.
704 Citizens Bldg.
Cleveland 14, Ohio

Hollister Tape Versatile

A DISPOSABLE measuring tape recently designed by Hollister provides a safe means of measuring infants at birth. The Baby Tape is made of sturdy moisture-resistant paper and may be autoclaved. After use, it may be given to the parents as a hospital memento, or it may be discarded. Marked in centimeters and inches, the 26-inch tape is long enough to measure the average-sized infant for several months.

The Baby Tape can be useful in any hospital department where a soft, non-metallic measure is desired. It can be used for measurements on hydrocephalic, orthopedic and thoracic patients.

Each tape is personalized with the hospital name, city and state without extra charge. Space is provided for recording birth information and infant growth. After use, the tape may be folded and permanently affixed in the baby's book. The tapes are packaged in boxes of 250.

Hollister, Inc.
833 North Orleans St.
Chicago 10, Ill.

Hypo Surgical Adds New Thermometer Line

HYPO SURGICAL SUPPLY CORP. has added a new clinical thermometer line to its present line of needles, syringes and specialty items. Manufactured to conform with the "HYPO" Seal of Standards, Hypo thermometers are available in oral, rectal or stubby types and are popular-priced to meet most budgetary requirements. "Easy-Read" Markings are etched into thermometers and contain permanent silicon pigment for long and daily usage without rubbing off. All thermometers are color-coded red above normal. Every thermometer will meet all federal and commerical specifications and is fully guaranteed for durability and accuracy in compliance with CS1-52 standards.

Thermometers are packaged individually, six dozen to a container. A special pack is also available packed one dozen per "See-Thru" plastic box.

Hypo Surgical Supply Corp.
11 Mercer Street
New York 13, N.Y.

J & J Adds Sponge to "Patient Ready" Line

ANOTHER STERILE *patient ready* Gauze Sponge, packaged in a heat-sealed, bacterial barrier paper, has been added to the line of Johnson and Johnson *patient ready* products.

According to the manufacturer, their 4 x 4, 12-ply gauze sponges have been made available in the tamper-proof, peelable seal package to fill the need for specialized post-operative dressings that require all gauze sponges.

J & J *Patient Ready* Sponge

The new sterile *patient ready* unit, with two gauze sponges per package, is reported to be less costly than comparable hand-wrapped, hospital sterilized packages.

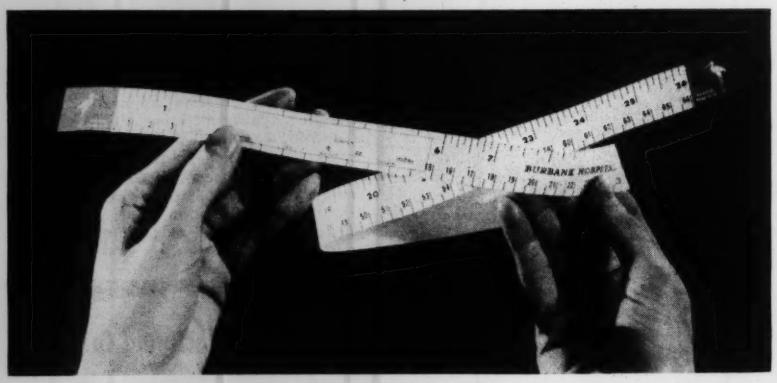
Johnson & Johnson Co.
Hospital Division Co.
New Brunswick, N.J.

Scientific Announces Marketing Innovation

A CHANGE in the marketing of precleaned microscope slides and cover glasses has been announced by Erie Scientific of Buffalo, N. Y. For more than 20 years its complete production of these items has been sold to the trade by Glasco Products Co. Glasco's operation as a distributor of glassware items has now been discontinued. Erie Scientific has, therefore, taken over distribution of its complete line of Selected Microscope Slides and Cover Glasses under the ESCO Brand name.

These products will continue to be available through better dealers throughout the U.S. and Canada. The prize-winning packaging will remain the same and all stock numbers will be retained for convenience in ordering.

Erie Scientific Co.
Buffalo, N.Y.



Hollister Disposable Measuring Tape

Baum V-Lok Cuff Reduces O.R. Hazards

W. A. BAUM CO. announces the Baumanometer *conductive* V-LOK Inflation System developed to reduce operating room hazards. Every component of this blood pressure accessory is conductive, fully tested and approved for use in anesthetizing areas.

V-LOK Cuff is made of finely woven fabric coated on both surfaces with Conductive Neoprene; utilizes new Velcro closure. Bulb, Bag and Tubing are all seamless, dipped in *conductive* Latex; including extra length (total

four ft.) Conductive Latex Tubing and AIR-FLO CONTROL Valve. Can be used with any blood pressure instrument; available through hospital and surgical dealers. Illustrated literature from the manufacturer:
W. A. Baum Co.
Copiague, Long Island, N.Y.

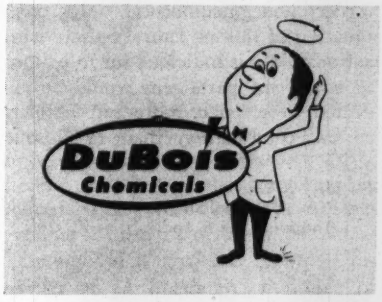
Colson Dolly Moves Cans Easily

A LOW COST portable steel dolly, designed specifically to move supply or refuse cans up to 18 or 20 inches in diameter, is now offered by the Colson Corp., Chicago, Ill. "Colson's Can Carry-All" accommodates cans of 10 to 50 gallon capacities. Constructed of rugged, flat steel cross supports and Colson plate casters, the dolly can be used effectively in institutional and restaurant kitchens, as well as maintenance and supply rooms.

The dolly can be set up in seconds and ready to roll. The cross members of the dolly are made of ⅛-inch by three-inch rust resistant cadmium plated hard rolled steel. Over-all dolly height is 3¾-inches. Available with two-inch or three-inch wheels, the dolly's weight capacity is 300 pounds.
Colson Corp.
7 South Dearborn St.
Chicago, Ill.

"Mr. Du" Makes Debut

A NEW TRADE CHARACTER named "Mr. Du," will be used by The DuBois Co.,



Inc., nationally known cleaning compound manufacturers, as part of its 40th anniversary promotions in 1960 and thereafter.

"Mr. Du" will be used in the company's advertising and promotions to represent its sales force of over 500 men throughout the U.S., Canada and parts of Latin America. A distinguishing feature of "Mr. Du" is a halo which repeats the oval shape and accent mark of the company's recently-adopted trade mark.
The Du-Bois Co., Inc.
1120 W. Front Street
Cincinnati 3, Ohio

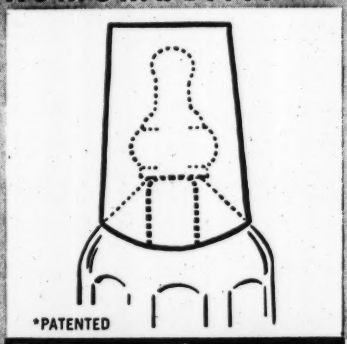
Eli Lilly Offers New Oral Suspension

AN ORAL SUSPENSION combining the triple sulfas with a salt of Ilosone® is now available. Ilosone is an Eli Lilly antibiotic which provides prompt, potent and prolonged therapeutic activity in the blood.

Lilly is introducing Ilosone® Lauryl Sulfate Sulfa, for oral suspension, in a dry, pleasantly flavored mixture. Each bottle contains 60 cc. of suspension after the dry granules are mixed with 43 cc. of water.

Each five cc. (approximately one teaspoonful) of suspension contains as

Remember...



for quick, dependable protection to nursing bottles . . . use the original NipGard* covers. Exclusive patented tab construction fastens cover securely to bottle • For High Pressure (autoclaving) . . . for Low Pressure (flowing steam).

*PATENTED

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active ingredients: 125 mg. (base equivalent) of Ilosone Lauryl Sulfate and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine.

Ilosone has been used extensively in the management of a wide variety of bacterial infections, with no evidence of serious toxic manifestations. In addition, allergic reactions are extremely rare.

Ilosone is particularly useful in infections caused by staphylococci, streptococci and pneumococci. The combination of Ilosone Lauryl Sulfate with sulfonamides is indicated for infections in which the pathogens would be expected to respond more satisfactorily to the combination than to Ilosone alone.

Eli Lilly & Co.
740 S. Alabama St.
Indianapolis 6, Ind.

Macbick Introduces New Hemofuge

BLOOD TYPING and cross matching procedures can be accomplished faster and more accurately with the new MacBick Hemofuge.

Completely redesigned and re-engineered, the handsome new Hemofuge is now equipped with a rugged million-start timer, integral splash guard-shield and rubber mounting pad.

Request Technical Bulletin HOF-4 for full details.

The MacBick Company
243 Broadway
Cambridge, Mass.

Pfizer Products Combines Antibiotics

STREP-COMBIOTIC, a new formulation of a highly effective antibiotic preparation, has been introduced by the Pfizer Laboratories. The drug contains the well-established antibiotics, penicillin and streptomycin, primarily for the treatment of certain mixed bacterial infections caused by susceptible organisms.

Dr. William C. Spring, Jr., medical director of Pfizer Laboratories, said the new compound is particularly useful against respiratory tract infections, urinary tract infections, acute gonococcal infections and bacterial endocarditis caused by susceptible organisms. Strep-Combiotic is administered intramuscularly and rarely produces pain or tenderness at the site of the injection.

Strep-Combiotic is a reformulation of Pfizer's Combiotic. This older and proven product combines penicillin with dihydrostreptomycin for treatment of a variety of infections. By substituting streptomycin for dihydrostreptomycin, the same therapeutic advantages will be available without some reported side effects of dihydrostreptomycin therapy, Dr. Spring said.

Chas. Pfizer & Co.
800 Second Ave.
New York 17, N.Y.

Physicians' Record Co. Develops New Form

PHYSICIANS' RECORD, publishers of hospital and medical records, now have a complete series of standardized record forms available for use with addressograph machines. The forms were developed at the request of many hospitals now printing with addressograph plates. A wide variety of these standardized medical records, such as graphic charts, nurses' notes, history, physical examination, physician's orders, progress notes and many others, are in stock for immediate delivery.

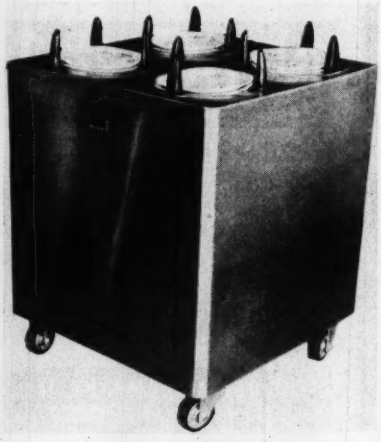
A "Portfolio of Standardized Record Forms for all hospitals using mechanical addressing equipment" will be sent on request.

Physicians' Record Company
3000 S. Ridgeland Avenue
Berwyn, Ill.

Swartzbaugh Adds New Dish & Tray Lifters

THE SWARTZBAUGH MFG. CO. manufacturers of IDEAL food service equipment, announces the addition of new tray and dish lifters to their line. These all-stainless steel dispensers combine efficient service with sanitary storage.

Dishes and trays are always main-



Ideal Dish Lifter

tained at the same convenient level, eliminating reaching or stopping by patrons and serving attendants. When the top dish or tray is removed, another automatically moves to the service level position.

IDEAL Dish Lifters have precision springs which automatically bring dishes to serving position. A top adjustment ring provides for adjustment of height of dishes above top deck level. By simply rotating the ring, desired level within coated posts is obtained. No tools are required.

To refill the IDEAL Lifter, merely place dishes and trays in position in the lifter. The elevators and precision spring mechanism expands or compresses in direct ratio to the load. Four swivel casters permit use as a mobile or stationary unit. IDEAL offers single, double, or four-stack Dish Lifters for any of the popular size dishes—either heated or non-heated. Tray Lifters are available for standard size trays. A full variety of Rack Lifters is also available.

The Swartzbaugh Mfg. Co.
Murfreesboro, Tenn.

Will Ross Tray Assures Medication Safety

A SAFE METHOD of transporting and dispensing patient medication, the Aren "Carry-Safe" Medication Tray is a practically designed 11 x 16-inch anodized aluminum tray, lightweight and easy to carry.

It has spaces to hold medicine cups, hypodermic syringes and identifying medicine cards safely and securely. The tray eliminates the danger of mix-up because of accidental jolting or tilting. It is available in two styles: A combination that holds 18 medicine cups

"Carry Safe" Tray

and four syringe racks; or the standard style that has space for 24 medicine cups, each with a slot in back to hold the medicine card upright.

Will Ross, Inc.
4285 N. Port Washington Rd.
Milwaukee 12, Wis.

SUPPLIERS' NOTES

American Cyanamid

James M. Board has joined the sales staff of American Cyanamid Company's Surgical Products Division as the division's representative in the Pittsburgh, Pa., area.

Donald E. Eveld is the division's new representative in the St. Louis, Mo., area.

Ansco

Herbert A. MacDonough has been appointed to the newly-created position of Manager of Product Marketing for Ansco, the photographic manufacturing division of General Aniline & Film Corporation. Mr. MacDonough is a graduate of the University of Michigan and a native of Port Huron, Michigan. For the past four years he has been Manager of Professional Product Sales. In his new position, Mr. MacDonough will direct the activities of Ansco's Amateur, Professional, Graphic and X-Ray Marketing Departments.

Baxter Laboratories, Inc.

Thomas F. Graham has been named by Baxter Laboratories, Inc., as a clinical research coördinator of the Northeastern United States. Graham, who lives in Havertown, Pa., joined Baxter in 1951 as a medical service representative.

In his new position, Graham will assist in establishing and maintaining contact with clinicians investigating the efficiency of new drugs.

A. C. Dalton has been named manager of Baxter sales services. Dalton, who joined Baxter 10 years ago, has served the company in several capacities including customer service manager, market analyst and office manager of the firm's Cleveland, Miss., plant.

Baxter, with its Hyland, Travenol and Flint-Eaton division, is a manufacturer of pharmaceuticals. Its Wallerstein division produces enzymes for industrial uses.

S. Blickman, Inc.

The appointment of **Allen Diefendorf** ("Dief") as Southeastern District Representative of S. Blickman, Inc., Weehawken, N.J., has been announced by **Ted Anker**, Hospital Division Sales Manager. S. Blickman, Inc., is a

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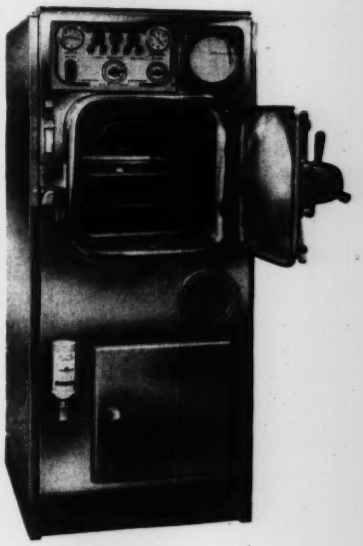

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With headquarters at 1060 N.E. 91st Street, Miami, Florida and an office in Nashville, Tenn., at 4010 Skyline Drive, Dief will cover Florida, Georgia, South Carolina, Tennessee, Kentucky, Mississippi and Alabama.

Wilmot V. Castle Retires

Wilmot V. Castle, president of Wilmot Castle Co., announced his retirement at a Board of Directors meeting held Dec. 28, 1959. He has been active in the prominent Rochester concern, which manufactures lighting and sterilizing equipment, for 47 years. **John H. Castle, Jr.,** vice-president, will succeed his uncle as president and **W. V. Castle, Jr.,** will become a member of the Castle Board of Directors, replacing his father who will, however, continue to act as a director of Ritter Co., Inc.

Klenzade Products, Inc.,

Norman K. Anderson, well known sales executive in the electrical products industries, has been appointed assistant director of sales for Klenzade Products, Inc., Beloit, Wis. He will work closely with **C. B. Shogren,** president and director of sales, in a sales expansion program already underway in the U.S., Canada, Mexico and other Latin American countries.

Parke, Davis & Co.

Parke, Davis & Company has announced the appointment of **Dr. John E. Gajewski** as assistant director of medical correspondence and assistant editor of *Therapeutic Notes,* the firm's medical journal.

Graydon L. Walker, vice-president and director of U.S. sales and promotion, said Dr. Gajewski would assume the newly-created position immediately. He joined Parke-Davis in 1949 as a member of the Clinical Investigation department, a position he held until his present promotion.

The Ritter Company, Inc.

Joseph P. Fox, treasurer of Ritter Company, Inc., since January 1, 1959 was elected a vice-president of the company at the Ritter Board of Directors meeting held in New York City Dec. 2, 1959. He is a member of the board and treasurer of Wilmot Castle Co. and a member of the board of directors and vice-president of Ritter Credit Corp.

J. B. Roerig

Anton G. Kettel has been named operations manager and **John L. Watters, M.D.,** medical director of J. B. Roerig and Co., pharmaceutical division of Chas. Pfizer & Co., Inc.

George B. Stone, Roerig general manager who announced the appointments, said Mr. Kettel will be responsible for all Roerig headquarters operations in his newly-created post. These include medical, marketing, advertising and public relations. **J. Otis Goettel** continues as sales manager in charge of the division's field force. Dr. Watters has served as associate medical director of the Pfizer Laboratories division since last June. He joined the company in January, 1959 as coördinator in the new products coördination department.

Simmons Company Buys Hausted

The successful conclusion of negotiations for the acquisition of the business of Hausted Manufacturing Co. by Simmons Co. has been announced jointly by **Grant G. Simmons, Jr.,** president of Simmons and **Ray Hausted,** president of Hausted.

Hausted, designers and producers of a line of top quality wheel stretchers and other hospital patient handling equipment, will become a division of the Simmons Co. Operation of the plant in Medina will continue with the same personnel as in the past. Mr. Hausted will become general manager of the Hausted Division of Simmons Company.

This acquisition will in no way affect present dealer sales organizations distributing Hausted products. Purchasers of Hausted wheel stretchers and allied hospital equipment will receive better service because the Simmons salesmen will now also offer the Hausted equipment, the spokesmen said.

Squibb Institute

Appointment of **Dr. Gordon Lindenblad** as research supervisor, Radioisotope Laboratory in the Section of Analytical and Physical Chemistry is announced by the Squibb Institute for Medical Research.

Dr. Lindenblad received a B.S. degree from Bates College, Lewiston, Maine in 1948 and a Ph.D. degree in biochemistry from Georgetown University in 1957. Prior to joining the Radioisotope Laboratory of the Squibb Institute in 1958, Dr. Lindenblad was associated with the Brookhaven National Laboratory, Walter Reed Hospital, Garfield Hospital in Washington, D.C. and the University of Wisconsin Hospital.

Swartzbaugh Manufacturing Co.

The Swartzbaugh Manufacturing Company of Murfreesboro, Tenn., reports the appointment of **James B. Eddins** as regional manager for the Southwestern Region. Mr. Eddins has replaced **Scott Reid** who will represent Swartzbaugh in a newly-established region on the West Coast.

W. R. Conklin, general sales manager, said that the appointment of Mr. Eddins gives Swartzbaugh nationwide coverage for its full line of IDEAL stainless steel equipment. Other Regional Managers are: **Jack Egan,** New England and Northeast Region; **Howard J. Behm,** North Central Region; **Austin Hansen,** Southeast Region and **Lou Fink** for the Midwest Region.

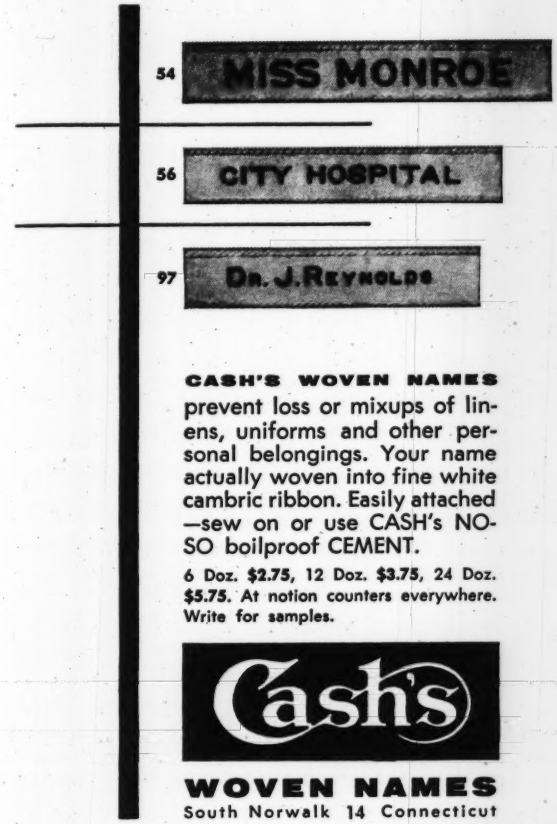
Wyeth Laboratories

The appointment of **Dr. Patrick T. McLoughlin,** Rosemont, Pa., to the medical division of Wyeth Laboratories, has been announced by **Dr. George E. Farrar, Jr.,** medical director.

Dr. McLoughlin received his undergraduate training at Fordham and Cornell Universities and his M.D. degree from Columbia University College of Physicians and Surgeons. He is an associate fellow of the American College of Allergists and has written several articles for medical journals.

Dr. Mahlon Z. Bierly, Jr., Wayne, Pa., has been named medical executive assistant to **Dr. J. H. Brown,** managing director of the Wyeth biological laboratories at Marietta, Pa.

Dr. Bierly has been with Wyeth Laboratories since 1954 as a staff physician concerned primarily with the clinical evaluation and medical aspects of biological products. A graduate of Franklin and Marshall College, Dr. Bierly received his M.D. degree from Jefferson Medical College. ★



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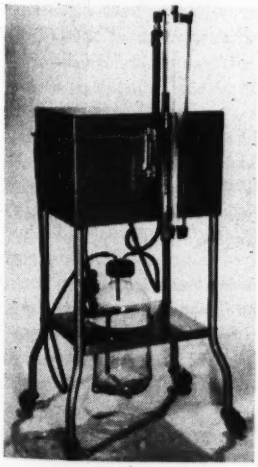

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—ROBERT J. DWYER, Bishop of Reno

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(Begins on page 98)

the $650 the student paid covered the expenses of less than half the first year, the first changes initiated were administrative and concerned the financing of the program. At a faculty curriculum workshop, the program was developed in the main as it now operates. The planning was approached in as educationally oriented a manner as possible.

There will be no weekend, relief or night experience until the last quarter of the senior year. Without yet having clearly defined the objectives for these experiences, the faculty strongly favors retaining them as having an educational value for the students.

Fifteen hours of clinical experience are planned each week in the second and third years to be scheduled laboratory class hours as in any other course having laboratory hours. The laboratory hours are to be planned, directed, supervised and evaluated entirely by the instructor. For several years St. Mary's has had an instructor on each nursing station to which students are assigned, but only in the nutrition service—where the planning, patient assignment, etc. was done by the teaching dietitian—was really complete control exercised by the instructor. The new plan is not merely a cutting down of clinical experience hours, which would have no educational advantage, but it is to be a different kind of experience for the faculty as well as for the students.

The laboratory hours are Tuesday afternoon and Wednesday, Thursday and Friday mornings. This allows the instructors Monday and Tuesday mornings to orient themselves to the ward situation after the weekend. Tuesday afternoon is planned principally for the purpose of admission of patients by the students. They care for these same patients the following three mornings. Maternity nursing and the operating room use Tuesday morning because the afternoon is not a valuable time for experience in these two situations.

In her experience on the hospital nursing stations a student will inevitably render some service, but this is incidental, secondary and is compensated for in no way by the hospital. The student is PREPARING to give professional service, and it is obvious that she is not replacing either professional or auxiliary staff. It is of

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Publication Dept.
The Catholic Hospital Association
1438 So. Grand • St. Louis 4, Mo.

great importance that everyone view the student in this way. *How she sees herself, how the faculty, staff and patients see her has an influence on her fully entering the role of learner in the ward service environment.*

In developing this view of the student and in planning the program, the faculty members repeatedly encountered difficulty with their own deeply imbedded service orientation. As the faculty worked through this difficulty, the importance of the GOAL of giving service became increasingly clear. The objective is a fundamental change in attitude toward service. The student at the completion of the program should see herself as ready to BEGIN giving professional nursing care and assuming professional responsibility. If she, the faculty and staff have been fooled into thinking she was doing this during her student period, then giving service has been a means rather than an end. Furthermore, it is a false notion and it confuses the issue.

Because the faculty felt the need to develop in the student an increased awareness of patient needs, of improving the student's nurse-patient relationship, and of making the student's clinical experience more truly patient-centered, two further changes were made in the program. The hours of social science were increased by the addition of *Applied Psychology* once a week during the second year. An *Advanced Communication* course to be taught once a week has been added during the senior year. An *Interpersonal Relations* course is now taught once a week during the entire three years.

Using the old budget as a basis the direct costs were calculated at $1,500 per student per year. This included no attempt at estimating the value of student service, because this is considered an unrealistic kind of thinking. The next step was to cut out all nontuition items such as room, board, texts and uniforms before arriving at the tuition costs of $900, first year; $645, second year; and $645, third year—a total of $2,190.

As is generally true of three-year nursing students, St. Mary's students come principally from large families of the lower middle-income group. To solve the obvious problem posed by high tuition, the faculty devised the part-time work plan. The hospital administration has given the plan full support. A large number of part-time jobs were available in many areas: nursing service, admitting office, clinical laboratory, x-ray, pharmacy, purchasing, personnel, bookkeeping and the coffee shop. The hourly rate of pay for each of the three levels of students has been increased by administration since the program was inaugurated.

This part-time work plan of 10 hours a week the first year and 15 hours a week the second and third years is optional for the student (Table 1). She contracts with the hospital at the beginning of each quarter. While there have been most amicable relationships between the hospital department heads and the school in the working out of this plan, the program is the hospital's, not the school's, and the department head in all respects has an employer-employe relationship with the student working in the department. The total amount of time required in the educational program plus the part-time work does not exceed 40 hours per week.

About half the freshman students have elected this plan. Others, especially from out of town, go home each weekend and have a part-time job there. Many who live at home in Minneapolis have part-time jobs near their homes. All the second-year students are on the plan. It is hoped that a large number of students will remain to work during the summer on a full-time basis.

Students living within commuting distance of the school are encouraged to live at home. It was expected, because of the considerable added expense of living in the nurses' residence, that many local students would elect to live at home. Room charge is $20 per month double or $25 per month single. Four second-year students moved home and 12 freshmen live at home. Even with rather strict regulations and hours, the nurses' residence seems to represent a step of independence for students and they like dormitory life!

As this plan has developed and been put into practice, unexpected problems have been encountered and unexpected advantages identified. The largest of the surprise problems was with food. The junior students were put into this program in September, 1959, after having entered the previous year under the old plan. The prospect of paying for meals in the cafeteria seemed to overwhelm them, but they probably were expressing other things, too. They immediately set up light housekeeping on a large scale. A cooling-off period

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